PHYSICIAN PAYMENT REVIEW COMMISSION

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Annual Report to Congress

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PHYSICIAN PAYMENT REVIEW COMMISSION

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Annual Report to Congress

Acknowledgements

This marks the tenth year that the Physician Payment Review Commission has submitted an annual report to the Congress. As in previous years, this year's report presents work conducted by the Commission and its staff as well as by outside experts, and reflects the Commission's ongoing relationship with physicians and other health professionals, consumers, payers, and others affected by its work. The Commissioners and staff would like to thank all those who have contributed to its work in the past year. Staff of the Congress, the Health Care Financing Administration (particularly the Bureau of Data Management and Strategy) and other agencies of the Department of Health and Human Services, the Congressional Budget Office, the Congressional Research Service, the General Accounting Office, and the Prospective Payment Assessment Commission provided invaluable information and advice to the Commission.

This year the Commission has been fortunate to continue to work with a group of people who have consistently understood and responded to its needs in key areas. Social and Scientific Systems—especially Arlene Turner, Jeff McCartney, and Rosanne Russillo—upheld their excellent record of meeting the challenges posed by the Commission's diverse programming needs. Lynn Lewis again contributed her talent as an editor to this report, working closely with staff on effective ways to convey complex and technical material.

As in years past, the Commission benefited greatly from work conducted under contract that provided new data for its analyses and deliberations. Julie Schoenman, Marc Berk, and Curt Mueller at Project HOPE were instrumental in conducting and completing the Commission's 1994 National Survey of Physicians. Special thanks also go to William Lessard, Jr. at the National Committee to Preserve Social Security and Medicare for his work on "hotspots" of beneficiary access problems. Commission-funded research by Zachary Dyckman and Aaron

Knowlton of the Center for Health Policy Studies was instrumental to the Commission's analysis of methods for managing fee-for-service Medicare.

As part of its ongoing study of the changing health care market, the Commission convened a number of expert panels to discuss how these changes might affect Medicare. Staff of Mathematica Policy Research played a key role in identifying and convening these panelists. Panel participants provided the Commission with invaluable perspectives on beneficiary concerns related to Medicare restructuring, the design of a multiple choice insurance system, plan standards, Medicare managed care, and vulnerable populations in managed care. For sharing their insights, special thanks go to Fred Abbey, Susan Aldrich, Ellen Aliberti, Joe Anderson, Cary Badger, Helen Barakauskas, Dennis Beatrice, Tanya Bednarski, Robert Berenson, Kathy Burek, Kathleen Cameron, Alfred Chiplin, Gary Claxton, John Conniff, Peter Connolly, Janet Corrigan, Marty Corry, Carol Cronin, Rick Curtis, Joseph Davis, Mary Frances Flynn, Peter Fox, Robert Friedland, Aileen Harper, Dwaine Hartline, David B. Helms, Bonnie Hillegass, Jim Hillman, William Hoffman, Cathy Hurwit, Mark Joffe, Henry Kirby, Dennis Kodner, Peter Kongstvedt, Brian Lindberg, Trish MacTaggart, Joseph Martingale, Suzanne Mercure, Martha Mohler, James Morrison, Marilyn Moon, Carmen Ness, Tricia Neuman, Eileen O'Donnell, Alan Peres, Christine Petersen, Louise Probst, John Ramey, Judy Riggs, Louis Rossiter, Diane Rowland, Debbie Scholem, Gerry Shea, Shoshanna Sofaer, Margaret Stanley, John Strube, William Thomas, Carol Tobias, Judy Waxman, Sandy Harmon Weiss, Steve Wetzell, Barbara Yondorf, Carlos Zarabozo, and Steve Zatkin.

The Commission's work on monitoring beneficiary access continued to be guided and informed by the Commission's Advisory Panel on Access. Thanks go to Perham Amsden, Geraldine Dallek, Lynn Etheredge, Harold Freeman, Lucian Leape, Stephen Long, Nicole Lurie, Ira Moscovice, Martin Shapiro, Richard Tompkins, and Barbara Yawn.

In an effort to inform the Commission as well as the Congress about the evolving market for health services, Commission staff participated in several site visits to markets undergoing rapid change. Staff also visited specific managed-care plans that had participated in a previous Commission-sponsored survey to gain a more in-depth understanding of emerging relationships between plans and their physicians. Special thanks go to Marsha Gold, Robert Hurley, Anna Aizer, Meghan Bloome, Hilary Frazer, Tim Lake, and Bob St. Peter from Mathematica Policy Research, who were instrumental in organizing those visits.

Throughout the year, the Commission seeks comments on its work from many organizations concerned about the issues on its agenda. The information it receives through formal testimony, comments on draft chapters, and interactions with these groups always enhances its work, and it appreciates the efforts made by these organizations.

A number of other people played a key role in Commission activities during the past year. For their efforts, special thanks go to Marty Abeln, Charlie Adams, David Blumenthal, Cathy Burt, Gary Clarke, Ken Cohen, Therese De Caro, Frank Eppig, Beth Fuchs, David Gibson, Kurt Gillis, Mel Ingber, Terry Kay, Kathy King, Jeff Lemieux, Jesse Levy, Marion Ein Lewin, William London, Hal Luft, Ted Lyle, Renee Mentnech, John Ninomea, Michael O'Grady, Larry Ozanne, Greg Pope, Linda Quick, David Richardson, Jamie Robinson, Jack Rodgers, Margo Rosenbach, Robyn Tarantino, Michael Taylor, Sherry Terrell, Don Thompson, and Julie Walton.

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Summary and Recommendations

Concerns about the federal budget deficit, as well as the evolution of the American health care system toward integrated delivery systems, have made restructuring the Medicare and Medicaid programs a priority for many policymakers. With strong pressure to reduce the federal budget deficit, slowed growth in premiums for private insurance has created expectations that greater penetration of managed care in Medicare and Medicaid will help moderate increases in federal spending. Moreover, opening up these programs to more innovative methods of service delivery and payment than permitted under current law may result in a better match between program offerings and beneficiaries' needs and preferences. At the same time, key protections for beneficiaries may become even more important as they face new and unfamiliar ways of receiving services.

Various changes to Medicare have been proposed, based primarily on the notion that beneficiaries should be able to choose from an expanded array of health plans. Over the past year, the Commission has analyzed several issues raised during debate on these proposals, building on its previous analyses of Medicare's risk-contracting and traditional fee-for-service programs. There are three types of Medicare-related issues addressed in this report—those related to broadening choice, those within the traditional Medicare program, and those that affect both the expanded and traditional programs and the relationship between them.

Proposals to change Medicaid have focused on reducing federal requirements and controlling federal and state spending for the program. In general, studies credit Medicaid with improving access to health care services for beneficiaries relative to the uninsured. Major criticisms of the program include the lack of coverage for all the poor, considerable growth in program costs, and increased federal direction of the program. Current program characteristics, proposed program changes, and the continued need for a mechanism to monitor access are all addressed in this report.

Expanding Plan Options for Medicare Beneficiaries

Although Medicare beneficiaries have had the option of selecting managed-care plans for more than a decade, this option has not been uniformly available around the country and has been chosen by only a small percentage of beneficiaries nationally. During the past year, there has been extensive debate over ways to expand the array of health plan options available to Medicare beneficiaries.

Until recently, the only private health plans available to Medicare beneficiaries were health maintenance organizations (HMOs). Most are paid under a full-risk contract, while a few use cost-based contracts. Enrollment in risk-contracting plans has more than doubled in the past four years, but still accounted for only 8.8 percent of beneficiaries in 1995. Combined enrollment in risk and cost plans was 10.7 percent. Enrollment growth seems to have resulted from both rising interest among newly eligible beneficiaries and even faster increases for those who have been in Medicare for a year or more.

Enrollment is concentrated in a few areas of the country. Six states account for two-thirds of enrollees nationwide, with almost half in California and Florida. Managed-care penetration varies widely across the country, but has topped 25 percent in only four western states.

Some new managed-care options are now available to Medicare beneficiaries. Point-of-service (POS) options were recently added on a limited basis by some Medicare risk contractors. Medicare SELECT allows beneficiaries to purchase a Medigap policy that provides full supplemental coverage through a preferred provider organization (PPO) or HMO. More options should be available as soon as the Health Care Financing Administration (HCFA) awards contracts in a new demonstration project called Medicare Choices. But even with additional offerings in some regions, Medicare will not reflect the extent of recent delivery innovations available in the private sector.

The number and variety of managed-care options in the private sector have increased dramatically in the past few years. At the same time, the traditional categories of managed-care plans have become less salient as companies offer new products and modify old ones in response to purchasers' demands.

A typology that describes the relationships of plans to purchasers and enrollees differentiates plans along two dimensions: the extent to which they bear financial risk for their enrollees and the extent to which they

lock enrollees into a particular group of providers for a specific period of time. Many combinations of these two elements can be found in the private market, and some of these may be of interest to Medicare.

One common option, the traditional HMO that pays only for services delivered by network providers and accepts full risk from the purchaser, corresponds to the Medicare risk contract. Private purchasers, however, are increasingly interested in partial-risk or fully self-funded relationships with these plans. The Medicare Choices demonstration is exploring partial-risk arrangements for Medicare.

The fastest-growing arrangements in the private sector are plans (including PPOs and point-of-service HMOs) that allow beneficiaries to be reimbursed for use of nonnetwork providers. Many private purchasers contract with these plans with something other than a full-risk contract. Medicare's POS option may test the popularity of this approach with beneficiaries under a full-risk arrangement. Further experimentation with these and other arrangements may require legislative authorization.

As the implementation of any new system of Medicare private health plan options proceeds, a well-designed monitoring process will be important for assessing whether policy changes achieve their purpose. Such a process should evaluate how reforms affect participating health plans, beneficiaries, and the Medicare program. It should continue long enough to track both immediate and delayed responses by plans and beneficiaries and should represent different regions of the country.

Standards for Plan Participation in Medicare

Broadening the range of private health plan options in Medicare presents not only an opportunity but also the challenge of maintaining a high level of quality and access to care and protecting beneficiaries from unfair marketing practices and potential plan insolvency. This challenge is heightened if Medicare allows new and untested forms of health plans to enroll Medicare beneficiaries.

Current Medicare law establishes a set of specific requirements that all plans must meet to participate under the program's managed-care options. These relate to aspects of plan operations such as financial solvency, quality, access, enrollment, marketing, and benefit offerings. The applicability and content of these standards to a broader set of plans must be considered if beneficiaries' choices are expanded.

The application of standards to plans of different types is a difficult issue. Although Medicare standards are determined federally, they often defer to state laws and regulations. State laws have attempted to distinguish between standards that should apply to HMOs accepting full-risk arrangements and those affecting PPOs that are not at risk. More recently, some states have tried to develop appropriate standards for provider-sponsored organizations (PSOs), which may take on full-risk, partial-risk, or no-risk relationships with purchasers. Variations in plan design may require that different approaches are used to implement standards. The challenge is to permit flexibility while ensuring attainment of desired outcomes.

Recommendation

The same core standards should be applied to all private health plans participating in Medicare. Flexibility should be used in developing and enforcing standards and rules as appropriate given differences in plan design.

Standards for beneficiary financial liability may become more important as beneficiaries choose among plans on the basis of differences in benefits and cost sharing. Traditional Medicare has offered limits on out-of-pocket costs for physicians' services, with comparable protection available under the risk-contracting program. The Commission has concluded that such protections should be extended to new coverage options for those services delivered by network physicians, in emergencies, or as a result of authorized referrals. Because protections are not guaranteed under other circumstances, the Commission proposes that beneficiaries be informed about their potential liability and that the amount of out-of-pocket liability be monitored.

Recommendations

Under a private health plan participating in Medicare, a beneficiary's financial liability for services delivered by network providers having a contractual relationship with the plan should not exceed (after taking into account any deductible and copayment) the liability the beneficiary would have had with participating providers under traditional Medicare. For emergency services and authorized referrals by the plan to nonnetwork providers, the same limits on a beneficiary's liability should apply as would for services delivered by network providers.

Informational materials provided to Medicare beneficiaries during any open enrollment season should describe the potential out-of-pocket liability (including any possibility of balance bills) that could be incurred by enrollees in all private health plans, as well as under traditional Medicare.

Current responsibility assigned to both the Secretary of Health and Human Services and the Commission for monitoring beneficiary financial liability in traditional Medicare should be extended to beneficiaries enrolled in private health plans participating in Medicare. Approaches to collecting data should be developed to support this activity.

Facilitating Beneficiary Choice

As the array of private plan options available to Medicare beneficiaries expands, certain steps will be necessary to facilitate beneficiaries' ability to make informed choices. Most policymakers agree that a key first step to promoting effective choice is to create a structured information and enrollment process. Beneficiaries' ability to choose among options will be enhanced by the broader availability of comparative information on plan characteristics. Beneficiaries should be protected from marketing approaches that do not accurately represent the available choices.

Under the current Medicare risk program, the enrollment process is managed by health plans, which can decide when to enroll beneficiaries; plans also receive enrollment applications directly from beneficiaries. Those who enroll have the right to disenroll from their plan at any time. Within the first three months, only 2.6 percent of enrollees leave the risk program; most stay for at least a year.

One of the key issues in the debate about restructuring Medicare has been the design of a more structured enrollment process. Last year, the Commission recommended that coordinated open enrollment was necessary to ensure that beneficiaries have full comparative information on their options. Implementing such a policy raises several issues, including the timing of open enrollment for plans and the length of time beneficiaries must stay enrolled.

If the Congress chooses to eliminate the current option giving beneficiaries the right to disenroll at any time, certain protections for beneficiaries should be adopted. This would protect beneficiaries who enrolled under false pretenses or made ill-informed decisions. For example, beneficiaries might be allowed an unrestricted disenrollment option during the first 90 days after enrolling.

Recommendations

Under an expanded Medicare program, the current policy of retroactive disenrollment should be available to beneficiaries who fail to understand the consequences of their choice of a private health plan option.

If there is an annual lock-in requirement for beneficiaries and if a plan makes a major change in its network of providers during the year, beneficiaries should have the right to disenroll before year-end or to purchase services on a special point-of-service basis for the rest of the year. The exact circumstances under which such a policy would be invoked should be specified in regulations.

Information plays a critical role in beneficiaries' decisionmaking about plans. The Commission has considered what beneficiaries need to know about their options and the importance of this information to an effective choice-based program. Several key steps still need to be addressed, including creating materials responsive to beneficiary needs, developing effective dissemination methods, and providing enough resources to accomplish these goals.

Recommendation

The availability of comparative information on plan options will be critical to ensuring meaningful beneficiary choice. Sufficient resources should be made available to support development and dissemination of informational materials.

In addition to providing information on a plan's costs, benefits, and network of providers, the Commission supports the need to inform beneficiaries about the financial incentives facing plan providers.

Recommendation

Plans should disclose information about the general nature of the financial incentives faced by providers who contract with a health plan.

Current Medicare policy permits plans to distribute information about plan features to beneficiaries in their service area. Continuation of several rules that have protected beneficiaries in the marketing process is important under any restructuring.

Recommendation

Explicit marketing provisions included in current regulations should be incorporated in any new regulations developed for private health plans participating in Medicare. These should include prohibitions on discriminatory marketing practices, misrepresentation of the Medicare program or the plan, door-to-door solicitation, and the giving of gifts or payment to prospective enrollees.

All marketing materials distributed by health plans participating in Medicare should use standardized definitions developed by the Secretary of Health and Human Services to the extent feasible.

Recommendation

A final issue is whether it is preferable for enrollment to continue being conducted by plans or if this role should be assumed by the Secretary of Health and Human Services. The difference between these options would have less significance if all beneficiaries received a standard enrollment application and thus could enroll in a private health plan without relying heavily on direct contact with the plan.

The Secretary of Health and Human Services should provide an enrollment application as part of the comparative information package given to all beneficiaries.

Recommendation

Medicare Capitation Payments

Currently, only Medicare risk-contracting plans are paid on a capitated basis, using a method based on adjusted average per capita costs (AAPCCs) in the Medicare fee-for-service program. Inadequacies in this methodology have contributed to uneven participation by health plans and beneficiaries across the country. Several congressional proposals would use 1995 AAPCC rates as the starting point for setting capitation rates, but would correct some problems with the AAPCCs and uncouple rates for succeeding years from fee-for-service expenditures. Under current proposals to restructure Medicare, a single capitation payment method would determine payment for all types of private health plans offered.

Shortcomings of existing AAPCC-based rates include wide geographic variation in payments, payment volatility over time, inclusion of medical education and disproportionate share hospital payments that may not reflect use of these providers by plans, exclusion of certain health care expenditures such as for care provided by the Department of Veterans Affairs, and limits on Medicare's ability to recapture cost savings achieved by participating health plans. In addition, the current risk adjustment of AAPCC-based payments captures only a small fraction of differences in enrollees' health care costs.

Variation and volatility in payments have influenced Medicare enrollment rates in risk plans, which tend to be greater where payment rates are high and their volatility is low. Several methods—blended rates, payment floors

or ceilings, and differential updates—have been considered to reduce geographic variation in rates because of local service use patterns while allowing for variation in input prices faced by plans. Volatility, which results primarily from basing payments on the experience of small populations in some counties, could be reduced in a variety of ways as well.

Legislation considered by the Congress has tried to address problems with the AAPCC methodology, using several policy options. The Commission estimates that, in general, these proposals would reduce geographic variation in capitation rates moderately, primarily by raising very low rates. They also would reduce payment rate volatility by uncoupling capitation rates from Medicare fee-for-service spending.

Mechanisms will be necessary to monitor the effects of any change in the capitated payment method. Such a monitoring process should examine a variety of issues, including whether lower-than-average rate increases in areas with currently high rates lead to benefit reductions by plans and subsequent disenrollments and whether larger-than-average rate increases attract health plan participation in small markets. In addition, analyses should examine how differences between capitation rates and fee-for-service per capita costs within local markets affect the choices available to beneficiaries, their enrollment decisions, and resulting Medicare costs.

Promoting Quality of Care

As envisioned by the Commission, a system of quality assurance under a restructured Medicare program should differ from the current one in two respects. First, some changes in current standards for ensuring quality and their application would be required so that the system could accommodate a wider variety of health plan models. Second, the system should incorporate appropriate private-sector innovations, such as performance measurement and reporting approaches. Doing so would foster development of common standards of quality for Medicare beneficiaries and private-sector enrollees, and could ease the burden on health plans of complying with the requirements of multiple purchasers and regulatory entities.

The goal of a quality assurance system under a restructured Medicare program would be to continuously improve quality of care in all participating health plans, regardless of delivery model. This goal may best be achieved by establishing uniform standards for quality, although methods to meet those standards may vary across plan models.

All health plans that serve Medicare beneficiaries should be subject to the same standards to promote quality of care. Specific methods for meeting those standards may differ as appropriate, given differences in plan design.

Recommendation

By facilitating informed choice, health plan performance reports could serve as a valuable component of a quality assurance system. To the extent that beneficiaries are able to interpret and act upon the information provided in performance reports, plans presumably would be motivated to maintain high levels of quality in order to compete for enrollees. The value of performance reports for helping beneficiaries assess health plans depends on the extent to which the reports can capture a range of important dimensions of health care quality and plan performance.

Medicare restructuring legislation should require all health plans serving Medicare beneficiaries to participate in an audited system of consumer-oriented performance reporting that emphasizes measures of health care quality.

Recommendation

Disclosure of quality information potentially could enhance consumers' ability to determine the value of available health plans. But it would not, at least in the near future, preclude the need for other established approaches for promoting quality, including plans' internal quality assurance programs and external review.

Opportunities for health plans to operate internal programs to maintain and improve their quality of care differ by plan design. Because effective programs rely heavily on the participation and support of the plan's providers, the opportunities for plans without formal (i.e., contractual or employment) relationships with providers are limited. Some internal quality assurance activities, however, such as practice profiling, can be conducted by these nonnetwork plans.

All health plans that serve Medicare beneficiaries should be required to maintain internal quality assurance programs. Medicare's requirements for these internal programs should be consistent with established private-sector requirements, where they exist, and should reflect differences in plan design as appropriate.

Recommendation

In addition to internal quality assurance requirements, many purchasers and regulators have incorporated requirements for external review by an independent entity as a complementary approach to ensure the quality of

care a plan provides. External quality assurance programs can focus on the plan's capacity to deliver and ensure quality medical care; on the timeliness, appropriateness, and quality of care that is actually provided; or on both.

Recommendation

All health plans that serve Medicare beneficiaries should be subject to external quality review by an independent entity approved by the Department of Health and Human Services. Plans' internal quality assurance programs should be subject to periodic external review to verify that they meet established standards. External review should also include collaborative efforts to assess and improve quality of care on a continuing basis. Quality indicators and performance measures developed specifically for the Medicare population should be incorporated into external quality review activities.

Consumer protection requirements to foster quality of care should apply to all health plans that serve Medicare beneficiaries. Plans should be required to maintain procedures for beneficiary appeals of plan decisions not to provide or pay for a service, for timely resolution of beneficiary and provider grievances, and for notification of beneficiary rights and responsibilities.

Additional measures to safeguard quality and provide consumer protection are necessary beyond internal and external quality programs. Most consumer protection standards, other than those that relate to a plan's provider network, are applicable to managed-care and fee-for-service plans alike.

Medical Savings Accounts

Medical savings accounts (MSAs) have been proposed by the Congress as a new insurance option in Medicare. Beneficiaries choosing an MSA would exchange their traditional Medicare benefits for a high-deductible insurance policy and a contribution to a dedicated savings account. They would pay for their own health care up to the annual deductible by withdrawing from the savings account or paying out of pocket. The insurance policy would pay for most or all costs of covered services once the deductible was met. MSAs would give beneficiaries the option to insure against large expenditures while leaving themselves at risk for substantial (but not catastrophic) health care expenses. Introducing an MSA option in Medicare would raise several fundamental policy issues, including the likely increased cost to the program of such an option through self-selection, the current prohibition on certain types of plans from offering an MSA, and the possible effects of MSA enrollment on other publicly funded health care, such as Medicaid and public providers.

The basic theory behind the MSA is simple: a large deductible encourages individuals to use fewer health care services. But adapting private-sector MSA models to the Medicare context requires understanding the significant differences between Medicare and the private insurance market. Beyond the obvious difference between a younger, healthier population and an older, less healthy one, the typical private MSA differs from Medicare along several dimensions: self-selection (mandatory versus voluntary MSA participation), premiums determined through negotiation rather than by formula, the existence of alternatives for Medicare beneficiaries to protect against catastrophic costs, typical fee levels (Medicare discount), differing shares of low-income individuals, and insurance overhead costs. All of these factors may affect the likely financial performance of the MSA option in Medicare and the impact of this option on beneficiaries' health. The Commission has modeled the patterns of spending that might occur under a Medicare MSA based on assumptions about these various factors. These estimates, like those of other researchers, suggest that although beneficiaries selecting an MSA option would, on average, receive some financial reward, a substantial number would face a large increase in out-of-pocket spending for health care.

MSA options appear more likely than others to attract significant favorable selection. Beneficiaries who expect to spend little on health care in the coming year may disproportionately find MSAs financially attractive because they could keep more of the money deposited into the medical savings account. Conversely, those who expected high expenditures might find MSAs unattractive because it would be cheaper to buy Medigap insurance than to spend up to a large deductible. As a result, policies must be carefully considered to protect the Medicare program from increased expenditures due to selection.

Recommendations

The enrollment and disenrollment rules of Medicare medical savings account plans should be structured to reduce the potential for risk selection. Examples of restructured rules include a minimum enrollment period of several years in an MSA or requiring beneficiaries to announce their disenrollment from an MSA one or more years in advance.

If a Medicare medical savings account option is adopted, the Congress should require studies of selection into MSA plans both to determine what effect, if any, selection has on total program outlays and to identify a way to compensate for any selection that occurs.

Other elements of the design of a Medicare MSA option might also necessitate explicit policy decisions by the Congress. First, MSAs are typically envisioned in a traditional fee-for-service environment, but managed-care plans or other entities may be capable of offering them. Allowing these competitors into this segment of the market might require reconsidering current legal restrictions on the levels of deductibles and copayments that HMOs and other plans may use. In addition, plans offering MSAs, regardless of type, should be held to some minimum data reporting requirements.

Recommendations

If a Medicare MSA option is adopted, there should be no undue legal restriction of managed-care plans' ability to offer this product. Federal laws limiting deductibles and copayments or mandating benefits richer than the ones offered by Medicare should be waived for managed-care plans' Medicare MSA products. State laws should be preempted when they conflict with this provision of federal law.

Medicare MSA plans, to the greatest extent possible, should be held to equivalent types of requirements as other plans for the reporting of data to Medicare.

To make reasoned decisions regarding their financial risks, beneficiaries must have information on the extent of coverage under an MSA option. In particular, this means clear information on their potential liabilities for balance billing.

Recommendation

Medicare MSA plans should be required to disclose beneficiaries' typical (and potential) out-of-pocket spending including exposure to balance billing. This information should be provided to beneficiaries in a uniform format so that they can easily compare insurers.

Finally, there are issues regarding beneficiaries' ability to meet their financial obligations under an MSA option. Low-income beneficiaries may be the least able to manage the financial risks involved in an MSA. This might cause access problems if providers become less willing to treat beneficiaries without a guaranteed source of payment. Medicare MSAs also raise important coordination-of-benefits issues for beneficiaries entitled to Medicaid or other tax-funded health care.

Any Medicare MSA proposal should be structured to reduce the potential for adverse effects on low-income beneficiaries, on providers who disproportionately serve this group, and on Medicaid programs.

Recommendation

Medicare's and Health Plans' Coverage Decisions and the Appeals Process

Private plans participating in Medicare typically apply both substantive and procedural restrictions on access to particular services under specific circumstances. Beneficiaries and their providers will disagree at times with these restrictions. Such disputes are governed by federal law, which defines in general terms the services that must be provided and establishes a formal appeals process to resolve disagreements about whether specific services should be furnished to a beneficiary.

Health plans participating in Medicare are obliged to provide the full range of services available under fee-for-service Medicare. HCFA makes national coverage decisions for some services to Medicare beneficiaries; in their absence, Medicare carriers and fiscal intermediaries formulate coverage policies that apply only in their local area. Consequently, coverage policies may vary across areas. HCFA is now making changes in its coverage decisionmaking processes, a development the Commission finds encouraging.

Recommendation

The Health Care Financing Administration should continue its efforts to make more timely and nationally consistent evidence-based coverage decisions. These decisions should be communicated to private health plans that participate in Medicare and to the contractor that handles appeals of denials of service.

Inherent in the notion of managed care is the ability of health plans to select, to some extent, among acceptable alternate approaches to care for their patients. But there are no guidelines that describe the latitude permitted in making these choices. The role of cost considerations in these decisions is controversial, for example. These issues are likely to become more salient as enrollment of Medicare beneficiaries in managed care increases, particularly given pressures to reduce the rate of growth in Medicare spending.

Recommendation

The Health Care Financing Administration, with input from beneficiaries, providers, and health plans participating in Medicare, should provide guidance on the latitude that plans may exercise in choosing among alternate approaches to care.

Medicare requires health plans to provide or pay for care needed in an emergency, but what constitutes an emergency may be misunderstood or disputed by plans and beneficiaries. The definition of emergency is central to resolve such disputes and guide beneficiaries before they seek emergency care. Because beneficiaries cannot have full information on their condition when seeking emergency services, acknowledging this constraint in the definition of emergency care would help clarify this issue.

Recommendation

A prudent layperson's perspective should be considered as one of the factors in determining when a health plan that participates in Medicare should pay for initial screening and stabilization, if necessary, in an emergency.

When a health plan declines to provide or pay for a service that a beneficiary believes is covered under Medicare, the beneficiary may invoke a formal appeals process. Plans must reconsider their refusal to provide a service. An independent organization, under contract with HCFA, reviews all reconsiderations not resolved entirely in the beneficiary's favor. The process is slow, complex, and burdensome for beneficiaries and plans. Ideally, plans' internal systems should resolve most disagreements with beneficiaries. The Commission has identified several areas for improvement.

Recommendation

The Health Care Financing Administration should improve the appeals system as needed for health plans participating in Medicare by:

- *encouraging plans to develop better ways to prevent and resolve disputes;*
- *requiring plans to maintain a process to resolve pre-service requests within the time period necessitated by the beneficiary's condition, and requiring its contractor to reconsider such cases, when necessary, in a similar manner;*
- *ensuring that beneficiaries are informed about these processes; and*
- *holding plans accountable for the performance of their appeals systems, in part by collecting information on plans' performance and making it available to the public.*

Medicare Fee-for-Service Physician Payment

As transition to the Medicare Fee Schedule neared completion, physician payment patterns and policies continued to evolve. The distribution of Medicare payments to physicians changed between 1994 and 1995 because of the continued transition to the fee schedule as well as changes in relative values, the conversion factors, and the geographic practice cost indexes. Fee schedule payment developments in 1995 included activities to produce resource-based practice expense relative values for implementation in 1998, the five-year review of work relative values, and HCFA-sponsored analyses of ways to improve the definition of payment areas. HCFA also modified the rules for payment of investigational devices, which will, under certain circumstances, now be covered up to the payment amount of the alternatives they replace.

The distribution of physician payment has changed less under the fee schedule than originally anticipated. When the fee schedule was implemented, payments for evaluation and management services, including primary care services, were expected to gain relative to those for procedural services. These changes have occurred, but they were not as large as expected because of the use of separate conversion factors for surgical services, primary care services, and all other services.

Implementation of payment policy changes may affect the integrity of the fee schedule. Whenever relative values are changed, the relationship of values across codes and components of the fee schedule may be changed. Consistent with previous Commission recommendations on maintaining the fee schedule's integrity, HCFA changed the way it implemented payment policy changes for 1996 by achieving budget neutrality through the conversion factors rather than relative value units.

When the fee schedule was established, the Medicare payment shares allocated to its three components—physician work, practice expense, and malpractice expense—were calibrated to correspond to reported physician revenue shares. There is some evidence, however, that those revenue shares have been slowly changing.

Recommendation

Several implementation policies should be adopted to maintain the integrity of the fee schedule, consistent with the framework designed by the Commission in 1994:

- *Implementation of any changes to work relative values as a result of the current five-year review should be budget nentral with respect to work values and should not affect practice expense and malpractice expense relative values.*

- *The Health Care Financing Administration should continue to achieve overall budget nentrality by adjusting the conversion factors as it did for 1996, rather than by adjusting relative values, as it has in previous years.*

- *The relationship between the three components of the fee schedule should be rebased annually to reflect the three-year moving average of physician revenne shares as reported in national surveys.*

The Commission has long supported the introduction of resource-based relative values for practice expenses and malpractice expenses. Although new legislation has addressed the former, the latter will remain charge-based under current law. In addition, the activities under way to develop resource-based practice expense relative values have raised concerns for some stakeholders and analysts. These include HCFA's ability to develop values in time for implementation in 1998, the difficulty in collecting reliable data, and the lack of a clear plan for establishing values from the various research projects envisioned as part of the process.

Recommendations

The Congress should revise current law so that resource-based practice expense relative values will be phased in over a three-year period beginning in 1998. In addition, the Health Care Financing Administration should be directed to develop a process and timetable for refinement of resource-based practice expense relative values, which should be announced when proposed values are released for public comment.

The Congress should revise current law so that the malpractice expense component of the Medicare Fee Schedule will be resource-based. New malpractice expense relative values should be phased in over a few years. The Health Care Financing Administration should be directed to collect data on risk groups and relative insurance premiums across insurers that can be used to develop new malpractice expense relative values.

The Commission has also been concerned about continued use of payment localities that existed prior to 1989 as the basis for geographic adjustment of the fee schedule. These areas differ in size and number across states; although they do an acceptable job of they

are difficult to understand and administer. Moreover, in some cases, they result in large price differences at borders. HCFA has recently analyzed this issue and may make changes this year.

Recommendation

Fee schedule payment areas should be defined on a consistent basis nationwide. Area boundaries should be reanalyzed periodically and revised to reflect significant changes in within-area input price homogeneity and across-area price heterogeneity. Any metropolitan area that crosses state borders should have uniform geographic practice cost index values and be treated as if it falls entirely within the state with the largest share of its population.

Finally, the Commission is encouraged by HCFA's recent revision of its policies for coverage of investigational devices, which follows in part the Commission's previous recommendation on this subject. The new policy covers only devices that are enhancements of already-approved ones, though, and does not apply to new services. Broader policies are needed so that all devices and services being evaluated in federally approved studies are covered.

Recommendation

For devices subject to Food and Drug Administration approval, and for other services that the Health Care Financing Administration has not approved for coverage, Medicare should pay up to the cost of standard care when the device or service is clearly substituting for an established one and is being evaluated in a Food and Drug Administration or other federally approved study.

Improving the Volume Performance Standard System

The Volume Performance Standard (VPS) system curbs Medicare spending for physicians' services by linking payment levels to the growth in the volume and intensity of services. The system uses performance standards to set target rates of expenditure growth, and annually updates conversion factors depending on whether expenditure growth met the targets two years earlier. Methodological flaws in this system, however, prevent it from working as intended. A revision proposed by the Congress and the Administration, called the Sustainable Growth Rate system, incorporates many of the Commission's previous recommendations to correct the limitations associated with the VPS system. These include adopting a single

performance standard and update, basing performance standards on per capita growth in gross domestic product, and changing the method for calculating the conversion factor update to eliminate the two-year delay.

The Sustainable Growth Rate system would establish a single conversion factor that would remove the current distortion created by multiple conversion factors. The proposed system would also set a target linked to growth in per capita gross domestic product instead of the five-year historical trend for volume and intensity growth of physicians' services currently used under the VPS system. Conversion factor updates would be based on comparisons of total actual versus allowed spending accrued since a base year, replacing the year-to-year comparisons and two-year delay in the current system.

Because of the limitations of the current VPS system, physicians may face significant payment reductions regardless of how well they control the volume and intensity of the services they furnish. Under the proposed approach, payment could increase as long as volume and intensity remained at reasonable levels. If it did not, the system could result in larger penalties than are possible under the VPS system.

Although these changes correct many of the limitations of the VPS system, the proposed system has two limitations that are inherent in any administered price system. While the proposed system establishes more realistic targets, no such system can set targets that reflect appropriate levels of care or changes in the medical marketplace. Also, limits on the size of annual conversion factor updates are necessary for constraining volatility in annual adjustments. Otherwise, the updates would reflect year-to-year fluctuations in volume and intensity growth, as well as the changes necessary to recoup any excess or surplus spending in a single year. An additional limitation of both the VPS and the proposed systems, which results from incorporating projection errors into the calculation of conversion factor updates, could be readily corrected.

Recommendation

Any revision to the Volume Performance Standard system should annually correct for any projection errors in the target growth rate from prior years.

Managing Medicare's Fee-for-Service Program

Both Medicare and private indemnity payers have been introducing techniques for managing the delivery of health care on a fee-for-service basis. Identifying potential improvements for the Medicare program requires understanding current Medicare practice and the relevance of experiences in the private sector for refinements to those practices.

Results from a Commission-sponsored survey demonstrate the extent to which 10 innovative Blue Cross Blue Shield plans have adopted managed indemnity techniques. Four approaches were used by all or almost all the plans surveyed: case management, practice guidelines, rebundling of services, and provider profiling. Providing financial incentives for physicians was also considered important in reducing costs.

Many of Medicare's initiatives mirror those in the private sector. For example, various aspects of Medicare's provider profiling techniques and activities appear comparable to those of private payers. Profiling activities could be strengthened by comparing profiles with practice guidelines; this would make it possible to detect deviation from appropriate care rather than from common practice patterns. Another initiative is HCFA's recent implementation of changes to enhance its ability to detect the use of inappropriate billing codes. Medicare is also experimenting with case management through demonstrations and is investigating methods of paying for case management by using bundled payments.

Differences between the Medicare fee-for-service program and private payers may bear on the effectiveness of management techniques, and in some cases, the feasibility of implementation. As a public program, Medicare must operate differently from private payers. The Medicare statute also affects the program's ability to pursue certain strategies. For example, current law requires that all providers be able to participate in the program and that beneficiaries be guaranteed freedom to choose providers. These laws may complicate the implementation of management strategies that offer financial incentives to modify provider or patient behavior. Moreover, increased flexibility may be necessary in Medicare coverage and payment policies to accommodate management techniques such as case management.

In addition to continuing with the initiatives that are easily applied to Medicare, HCFA should explore ways that Medicare can make use of other cost-effectiveness techniques that appear promising yet conflict

with current policies. As a first step, Medicare may benefit by turning to its carriers for suggestions on how to integrate promising private-sector strategies into the program.

Recommendation

The Health Care Financing Administration should work more intensively with its Part B carriers and Part A fiscal intermediaries to implement the best private-sector practices for managing cost and quality of care within a fee-for-service context. This could include a formal request for proposals from carriers and intermediaries to test promising methods and increased financial flexibility to implement new management techniques.

Monitoring Access and Financial Liability for Medicare Beneficiaries

One of Medicare's major goals has been to improve beneficiaries' access to care and provide financial protection for them. By monitoring indicators of access and financial liability under the fee-for-service program, the Commission is able to assess for the Congress whether Medicare is achieving these objectives.

Access appears to be good for most beneficiaries. About 86 percent could identify a particular physician or physician's office as a usual source of care, and 96 percent reported no trouble getting care. At least 93 percent of beneficiaries reported great confidence in their physicians and satisfaction with the availability of care at night and on weekends. These results from the 1994 Medicare Current Beneficiary Survey are essentially unchanged from previous years.

Physician participation in Medicare and acceptance of assignment continue to grow. In 1995, 95 percent of physician claims for payment were paid on assignment. For the remaining charges not billed on assignment, beneficiary cost sharing has been effectively constrained by Medicare's limiting charge rules.

Claims data suggest that Medicare payment rates are adequate for the purchase of needed physicians' services. Despite reductions in some Medicare payment rates, beneficiaries' use of almost all services continues to grow. Where there have been decreases in use of specific services, they appear related to changes in medical technology or other factors rather than to changes in payment policy.

Comparison of Medicare payment rates with those of private payers shows that Medicare pays, on average, 71 percent of private rates. Higher Medicare payment rate updates and lower inflation in the private sector appear to have narrowed the payment gap since 1992, when Medicare paid 61 percent of private rates.

Since aggregate measures of access may mask problems in local areas, access monitoring includes analyses of potential hotspots of access problems. Data from a pilot survey, which asked respondents about difficulty finding a physician, show that geographic hotspots probably exist. In these areas, privately insured patients appear to have the same access problems as Medicare beneficiaries. More detailed study would be necessary to reveal whether the hotspots persist over time and to understand better the nature of reported problems.

Despite the finding that access appears to be good for most beneficiaries, the Commission remains concerned that problems persist for some vulnerable groups. Previous Commission analyses have shown, for example, that African American beneficiaries and those living in urban poverty areas and urban Health Professional Shortage Areas use fewer primary care services and more emergency room services than other beneficiaries. The Commission believes that no single solution will likely solve such problems. Instead, multiple approaches will need to be considered to maintain and expand service delivery for underserved Medicare beneficiaries.

For the future, access monitoring will need to evolve with the Medicare program. Increased enrollment of beneficiaries in managed-care plans has prompted development of a strategy for monitoring access in that part of the program, in addition to monitoring access in fee-for-service Medicare. The Commission is sponsoring a survey to provide baseline data on access of Medicare beneficiaries in managed-care plans and to inform efforts to collect this information on an ongoing basis. The Commission will also explore approaches that managed-care plans might use to identify and serve vulnerable beneficiaries.

The Failsafe Budget Mechanism

The congressional conference agreement includes a provision, called the failsafe budget mechanism, designed to limit growth in Medicare spending. This mechanism would set a spending ceiling for the program as a whole and reduce fee-for-service provider payments if projected spending

exceeded that limit. While the failsafe budget mechanism would safeguard against unrestricted growth in program spending, it was specifically crafted to meet deficit reduction objectives—scored savings of $270 billion by the year 2002 based on economic assumptions of the Congressional Budget Office (CBO).

The design of a mechanism to slow Medicare spending growth raises a wide range of policy issues. A key decision is whether to use an expenditure target, which adjusts payments to guarantee a certain average rate of growth, or an expenditure limit, which lowers payments to keep spending below a specified ceiling. In either case, additional decisions are required, such as determining an appropriate target or level of spending; allocating spending limits across service sectors (e.g., inpatient hospital services, physicians' services, home health services); adjusting sector allocations over time; addressing short-term fluctuations in Medicare expenditure growth; and ensuring consistency with mechanisms used to set payment levels within each service sector.

Each of these design decisions will have a different effect on payment levels, substitution of services across sectors, and the system's effectiveness. As they are made, compatibility with Medicare payment mechanisms must be considered. Potential approaches to constraining expenditure growth range from building spending constraints into the payment mechanisms of each service sector to developing an overarching mechanism applicable to all sectors. Predicting the potential impact of any system of expenditure limits or targets is difficult because it requires simulation models that incorporate Medicare's various existing fee-for-service payment mechanisms and how they would interact with a new system.

Several methodological limitations may keep the proposed failsafe budget mechanism from operating as intended. First, the mechanism only lowers payment levels and makes no provisions for increasing payment. Because payments would be dropped permanently to meet any anticipated excess spending, it would take larger reductions than needed in order to reach budget goals. In addition, payment reductions under the mechanism may reflect fluctuations in annual spending growth and errors in projections of spending. While the mechanism corrects for overspending that may have occurred two years earlier, it does not adjust for projections that were too high. The failsafe budget mechanism could be improved to better limit its effects on annual fluctuation in payment levels by revising the methodology so that savings in one year offset spending excesses in other years. This mechanism could also adjust for all errors in projections of spending.

If the failsafe budget mechanism is adopted, it should be modified in three ways. Any payment reductions should apply for one year only, and then payment levels should be returned to the level they would have achieved had the failsafe budget mechanism not been triggered. The mechanism should also be based on comparisons of total actual spending and total allowed spending accrued since a base year. In addition, it should correct annually for any projection errors regardless of whether these errors were too high or too low.

Recommendation

Geographic Adjustment of Medicare Payments

Within both its fee-for-service and risk programs, Medicare adjusts payments to plans and providers in different areas of the nation. Such adjustment policies require two distinct policy decisions: the areas within which the same payment rate should apply and the basis for adjusting payments across these areas. Under current policy, geographic variation in fee-for-service payment rates directly affects geographic variation in risk payments, which are based on each county's Medicare fee-for-service expenditures. Proposals to change the capitated payment method would change how geographic variation in risk payments relates to that in the fee-for-service program.

Geographic variation in per capita health expenditures stems from three distinct sources. First, local input prices differ nationwide. Second, differences in the local population's health status and other characteristics lead to differences in health service utilization rates. Finally, discretionary factors such as provider practice styles also lead to geographic variation in service use.

Fee-for-service and capitated payment methods address these sources of variation differently. Under fee-for-service payment, providers are compensated for all utilization variation, so geographic policies typically focus on local input price variation. Because capitated payment encompasses both prices and utilization, design of geographic policies must address both nondiscretionary and discretionary sources of utilization variation. Ideally, policies would hold plans and providers harmless for the former and create incentives to reduce the latter.

Geographic adjustment policies for Medicare fee-for-service payments to physicians were changed with the implementation of the Medicare Fee Schedule, while payment areas remained the same. There are three geographic practice cost indexes, corresponding to the three components of the fee schedule—physician work, practice expense, and malpractice expense. Based on data about professional wages and rents nationwide, these indexes are reviewed at least every three years. The Commission

has previously recommended redefining payment areas in a more systematic way, a change HCFA is considering.

Under current policies, Medicare risk payments are county-based; the geographic adjuster is the ratio of a county's Medicare fee-for-service per capita spending to a national mean. Recent proposals to change risk payments aim to decouple risk payments from fee-for-service spending. Several alternatives have been considered, each representing different decisions about how much utilization variation should be reflected in capitated rates. All such variation is now included in risk payments. At the other extreme, national per capita spending could be adjusted for local price variation only, thereby eliminating payment differences related to utilization. Limitations in existing risk adjusters suggest that the latter approach may be undesirable, at least in the short run.

Risk Selection and Risk Adjustment in Medicare

Risk selection will become an increasingly important issue as Medicare managed-care enrollment grows or new Medicare private plan options are offered. Some plans may attract beneficiaries with low expected health care costs (referred to as favorable selection), while others may attract beneficiaries with complex medical problems and high costs (referred to as adverse selection). Although Medicare's per capita payment should be adjusted to reflect the risk mix of each plan's enrollees, current risk-adjustment approaches capture relatively little of any biased selection across plans.

This raises at least three problems for the Medicare program. First, Medicare's costs increase if it pays managed-care plans more than it would have cost to treat the same enrollees in the traditional Medicare program. Second, the competitive process does not work as well when risk adjustment is inadequate. A poorly performing health plan may survive if it attracts low-cost beneficiaries, while a good performer may struggle if inadequately compensated for high-cost patients. Finally, inadequate risk adjustment of capitated payments may create barriers to care for beneficiaries with high-cost conditions.

The Medicare program currently has many rules aimed at reducing the potential for biased selection. For example, plans must accept all beneficiaries who wish to enroll and cannot deny coverage for preexisting health conditions. In addition, plans' marketing materials must be approved by Medicare.

Despite these rules, significant potential for biased selection remains. Numerous published studies have shown that beneficiaries who joined HMOs in the 1980s tended to have below-average costs in the period prior to enrollment. The Commission's analysis of more recent data shows that this is still true in the 1990s. New HMO enrollees' pre-enrollment costs are 20 percent to 40 percent below average, while those who disenroll from HMOs tend to have extremely high costs. Findings based on preenrollment and post-disenrollment utilization should be interpreted with caution, however, because neither new enrollees nor new disenrollees are typical of the average HMO enrollee. Hospitalization and mortality rates for new enrollees increase significantly during HMO enrollment (even after adjusting for the aging of the population), a phenomenon typically termed "regression toward the mean." The Commission plans to explore these results and their implications for risk adjusting payments to managed-care plans.

Progress has been made toward identifying a variety of techniques that could be used to improve the current risk adjustment of Medicare payments to plans. HCFA has developed approaches that use diagnosis data to predict beneficiaries' health care costs, and results suggest that these diagnosis-based risk adjusters offer a significant improvement over current Medicare risk-adjustment techniques. Alternatively, methods that would pay plans partly on a capitation basis and partly on a fee-for-service basis would also reduce overpayments and underpayments because of selection. As this work proceeds, data requirements and the need for testing and validation must be addressed.

Secondary Insurance for Medicare Beneficiaries

Roughly three-quarters of Medicare beneficiaries have some private health insurance in addition to their Medicare coverage. These secondary insurance policies typically cover some of the health care costs that Medicare does not pay, including Medicare cost-sharing requirements. Supplemental insurance coverage is available primarily from former employers or through a privately purchased insurance policy (typically referred to as Medigap insurance).

Though secondary insurance provides valuable financial protection to Medicare beneficiaries, it also has implications for the Medicare program. Higher utilization among Medicare beneficiaries with Medigap insurance translates directly into increased costs for Medicare. The Commission's analysis of data from the 1993 Medicare Current Beneficiary Survey confirms previous estimates that Medicare

beneficiaries with first-dollar supplemental coverage have rates of service use from 25 percent to 33 percent higher than those for beneficiaries without supplemental coverage.

Medigap insurers and Medicare risk-contracting plans operate under different rules governing their premium rate-setting and underwriting practices. This raises two important issues: the appropriateness of applying different standards to the two types of insurance coverage, and the implications that these different pricing strategies have for beneficiary access to and beneficiary choice of supplemental coverage. The artificial barriers to choice raised by these different rating and underwriting standards will become even more critical if the Medicare program is restructured to broaden beneficiary choice.

Options for modifying current supplemental insurance fall into three general approaches: revising current policy, creating partial risk-sharing arrangements, or allowing or requiring insurers to assume full risk for both Medicare and supplemental benefits. The current Medicare program provides examples of each approach. Medicare SELECT limits full supplemental coverage to services provided within the plan's network. Other demonstration projects allow secondary insurers to voluntarily accept partial risk for Medicare and supplemental benefits. The Medicare risk-contracting program and Medicare Insured Group Demonstration place plans at full risk.

Requiring insurers to accept full risk could be achieved through a policy of unified insurance. Under this approach, all insurance to supplement basic Medicare benefits would become replacement insurance. In such a system, supplemental insurers would assume responsibility for covering both Medicare-covered services and any supplemental benefits they offered. Creating multiple Medicare options could give beneficiaries additional choices through a basic or supplemented plan offered directly by the Medicare program. Unified insurance represents a significant departure from the current system of supplemental insurance, however. The ramifications of moving to such a policy are not well understood and would have to be assessed before considering it as a viable option.

Supplemental coverage is important to Medicare beneficiaries, protecting them from the potentially large out-of-pocket costs associated with serious illness. Thus, the advantages and disadvantages of changing secondary insurance must be carefully weighed. Both the costs Medicare faces under the current supplemental insurance system and current efforts to restructure Medicare to increase competition and broaden choice

suggest that changes in the supplemental insurance market may be appropriate. The Commission expects to examine this issue further in the coming year.

Changing Labor Market for Physicians

With policymakers' attention focusing on the potential benefits of a competitive health care market, some have argued that problems of physician oversupply and specialty imbalance are among those that will be resolved by the market. This change is expected to occur because of the growth of cost-conscious integrated health systems that alter the number and mix of services used by patients, and thus the number and mix of health professionals needed to provide those services. These developments, it is argued, would result in physicians being employed at reduced compensation, with some being unable to find jobs in their specialties, thus sending a signal to students and educators to change their training and career choices.

The Commission has examined whether and how changes in the organization and financing of health care are affecting the labor market for physicians. Two types of change in the labor market have been assessed: whether there is evidence that increasing demand for primary care physicians is leading to changes in specialty mix, and if there is any indication that changes in the market have reduced the overall number of physicians being trained.

Previously, the Commission found that while there had been some changes in relative incomes and specialty choice, it was still too early to know whether these signaled a departure from previous trends. There were many anecdotes about changes in employment opportunities for different types of physicians, but no clear trend was evident in available data.

A review of more recent data suggests that change is occurring, but that it is more modest than suggested by anecdotes. For example, generalists' incomes have exhibited small gains relative to those of specialists, and both the percentage of senior medical students expecting to be certified in generalist fields and match rates for generalist residencies are increasing somewhat. Overall growth in the number of residents has declined, with the most substantial decreases in specialist fields. Growth in the number of international medical graduates in training may overwhelm any changes made in response to market dynamics by graduates of U.S. medical schools. Because

most data sources are national in scope, it is difficult to know whether change is more pronounced in the most competitive markets.

The Medicaid Program: Current Design and Options

Today's Medicaid program embodies three distinct features: joint federal-state financing, state administration in accordance with broad federal standards, and eligibility tied to state standards for other cash benefits. Some 37 million low-income persons who are aged, blind, disabled, or members of families with dependent children now receive medical services paid for by Medicaid. Rising medical costs, growth in disproportionate share hospital payments, changes in federal eligibility requirements, and expansion in program use by the elderly have made Medicaid one of the fastest-growing items in most state budgets. These budget pressures have led policymakers at both state and federal levels to explore ways to change the program.

Under the current policy, state Medicaid programs vary widely in eligibility and benefits, outlays per beneficiary, and the rate at which state funds are matched by federal contributions. In addition, program outlays per beneficiary differ across subgroups. For example, the elderly account for one-third of Medicaid expenditures, although they are only 12 percent of Medicaid beneficiaries. Many states have obtained federal waivers of particular program requirements to explore innovations in program payment and delivery systems. Most of these waivers have been used to expand managed care within state Medicaid programs.

Federal and state budget pressures have led to a host of proposals to change the Medicaid program. Proposals by the Congress would change Medicaid into a block grant program under which states receive set amounts of federal funds. Under this approach, individuals would not necessarily be eligible for Medicaid because they participate in other public programs or have incomes below a certain level. The Administration has proposed more modest changes aimed at allowing states more flexibility in designing and administering Medicaid while still maintaining federal standards and oversight. It would establish limits on federal spending per beneficiary.

Monitoring Access for Medicaid Beneficiaries

The Commission previously recommended that a strategy be developed for monitoring access within the Medicaid program. The likely effect of program changes on access to care is not well understood, but could be

substantial both for those the program serves and for those who would no longer be eligible. To understand the impact of any changes, access monitoring capabilities will need to be expanded.

A variety of measures may be appropriate for monitoring access within the Medicaid program, each with its strengths and weaknesses. These measures include indicators of care availability, site and timing of care, and health outcomes. Because causes of access problems may differ across communities, by service delivery system, and for different beneficiary subgroups, measures should be developed that can detect changes in access along these dimensions.

Four types of data may be used to monitor access: claims, encounter, hospital discharge abstracts, and surveys. These differ in information content, population included, comparability across programs and delivery systems, and timeliness. If states develop markedly different programs under Medicaid restructuring, nationally administered surveys or surveys meeting national standards and administered by all states may be crucial to analyzing and interpreting changes in Medicaid access.

The necessity for state accountability and the lack of available data that could support a comprehensive Medicaid access monitoring effort create the need for new monitoring systems. Such systems must account for differences in eligibility across states and develop approaches for comparing similar populations nationwide, regardless of state policies.

Recommendation

The Department of Health and Human Services should monitor access to care under the Medicaid program, and the Secretary should report on Medicaid access to the Congress on a yearly basis. Access of those with Medicaid coverage and others whose incomes fall below a specified percentage of the poverty level should be monitored. Eventually, monitoring should include state-specific estimates of access. As part of this effort, the Department should:

- *continue its development of a uniform Medicaid claims and encounter data system,*
- *require nonparticipating states to participate in that system, and*
- *develop and administer a periodic access survey of Medicaid beneficiaries and others with incomes below a specified percentage of the poverty level.*

The Context for Reform

Ten years ago, when the Physician Payment Review Commission was established, Medicare expenditures for physicians' services were growing at double-digit rates, placing an increasing burden on taxpayers and beneficiaries who share in financing program costs. The program's method of paying physicians on the basis of their historical charges had distorted the pattern of relative payments across physician specialties, services, and geographic locations. Concern was also growing about the increasing liability for out-of-pocket costs of Medicare's 30 million elderly and disabled beneficiaries, as well as their access to care. Physicians, policymakers, and beneficiaries alike agreed these problems had to be confronted.

Since passage of physician payment reforms under the Omnibus Budget Reconciliation Act of 1989 (OBRA89), many of these concerns have been addressed. Medicare's pattern of relative payments for physicians' services has been significantly realigned, as have those of many other payers that adopted Medicare's relative value scale. Physician payment updates are now linked to performance standards for slowing volume growth, giving Medicare a tool to hold down growth in expenditures for physicians' services. Balance billing—the practice of charging patients more than Medicare's allowed charge—has decreased dramatically.

In hindsight, however, physician payment reform has not been an unqualified success. In part this reflects inconsistencies within the policy that resulted from compromises made in crafting the reform. For example, distortions in relative values have been reintroduced owing to the existence of separate volume performance standards (VPSs) for different categories of services: surgical, primary care, and other nonsurgical. As a result, shifts in relative payments accomplished over the past several years will likely be reversed unless further legislative changes are made.

This chapter describes:

- *The policy context in which Medicare and Medicaid restructuring are being debated*
- *Concerns about the rate of growth in program spending*
- *The rapidly changing health care marketplace*
- *The need to correct other problems affecting Medicare*
- *The design and performance of Medicaid*

In addition, some expectations about payment reform's effects may have been unrealistic given the underlying incentives of fee-for-service medicine. Despite progress in slowing the rate of growth in physicians' services, for instance, overall Medicare expenditures continue to increase at a rate many consider unaffordable. At issue is the extent to which price constraints can hold down spending within the context of a fee-for-service payment structure or whether a more fundamental restructuring of the program, consistent with movement in the private sector toward capitated payment to organized systems of care, is necessary.

Today, there are also new challenges facing the Medicare program. Chief among these is how to respond to the changing nature of the U.S. health care system, with its growing emphasis on integrated systems of care; capitated payment; and new roles for purchasers, plans, providers, and consumers. Dynamic changes in the private sector have attracted policymakers' attention for several reasons. First, with strong pressure to reduce the federal budget deficit, slowed growth in premiums for private insurance has created expectations that increased penetration of managed care within Medicare will help moderate increases in federal spending. Second, opening up the Medicare program to more innovative methods of service delivery and payment than permitted under current law may result in a better match between program offerings and consumer preferences. Third, changes in Medicare may be required to maintain access for beneficiaries as the providers serving them become part of new integrated delivery systems.

Concerns about the level and rate of growth in Medicaid spending are also drawing the attention of policymakers. With Medicaid now one of the fastest-growing components of state budgets, budgetary pressures are motivating policymakers to consider block grants and significant changes in federal Medicaid rules.

These issues have been at the center of the policy debate in the 104th Congress. In November 1995, the Congress passed legislation that would fundamentally restructure the Medicare program and convert Medicaid from a federal entitlement for certain people to block grants to the states. This legislation was vetoed by President Clinton, whose Administration has offered its own approaches to reform. At this writing, the prescription for the future remains an open question, although it is clear that the debate is not over.

To provide a frame of reference for the topics addressed in this report, this chapter describes the challenges and problems affecting the Medicare and Medicaid programs that have set the stage for reform and places these in a policy context. These include concerns about the rate of growth in Medicare spending, interest in the rapidly changing health care marketplace, the need to correct problems troubling both the Medicare risk-contracting and fee-for-service programs, and criticisms concerning the design and performance of the Medicaid program.

GROWING RATE OF MEDICARE EXPENDITURES

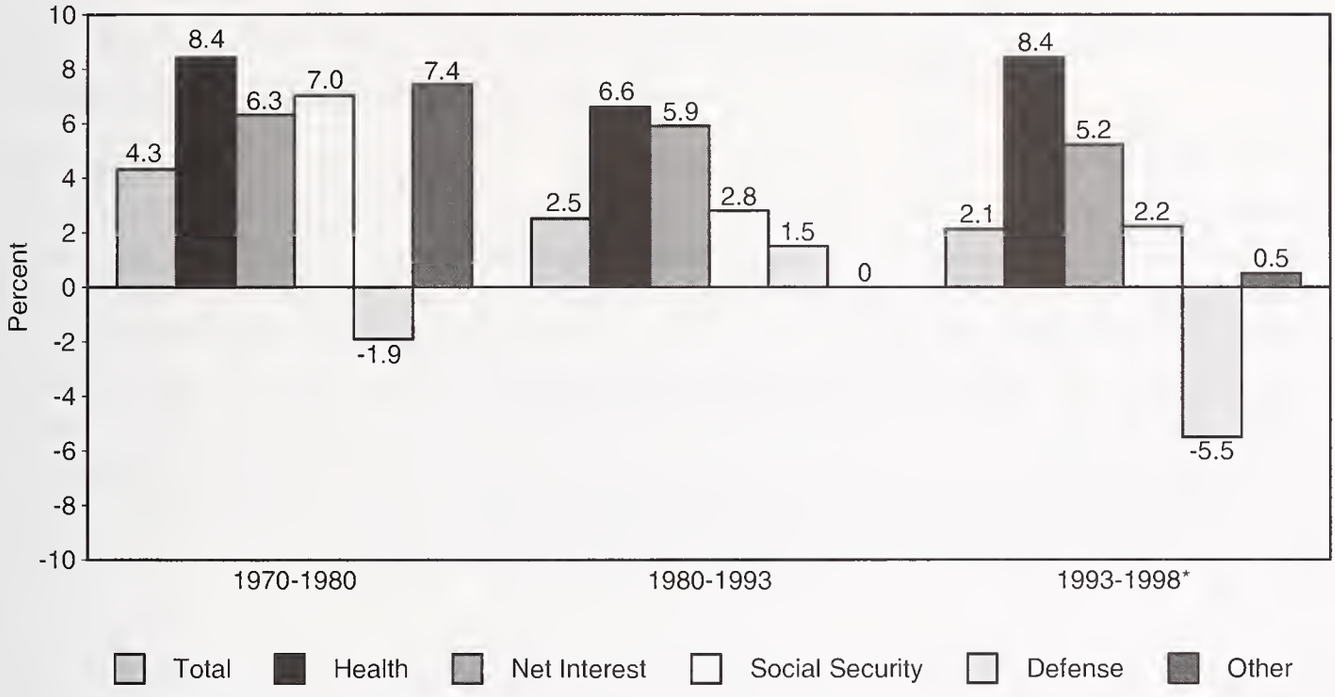
Concerns about the size of the federal budget deficit have dominated the public policy agenda of the 104th Congress. As policymakers seek ways to limit growth in federal spending, the Medicare program's size (roughly 20 percent of nondiscretionary federal spending) has made it central to the debate. At issue is how much the nation is willing to spend on health care for the elderly and disabled relative to other

competing needs such as education and law enforcement. Furthermore, recent data showing that private-sector health spending is growing more slowly than Medicare expenditures have reinforced the view that greater discipline in spending is possible without threatening access or quality of care.

Medicare and the Federal Budget

Medicare has been one of the fastest-growing major federal spending programs since the early 1980s, with expenditures rising at 7.7 percent annually between 1984 and 1993 (HCFA 1995a). Its growth has outpaced defense and Social Security, and today is second only to net interest payments on the national debt (CBO 1995c). And while Medicare expenditures are expected to continue accelerating at annual rates of 8.6 percent to 10 percent from now until 2005, rates of growth in federal outlays for other national priorities are expected to decline (CBO 1995a; CBO 1995b) (Figure 1-1).

Figure 1-1. Average Annual Growth Rates of Real Federal Outlays, Selected Components, Fiscal Year 1970-1998 (percentage)



SOURCE: CBO 1993.

* Based on Congressional Budget Office projections.

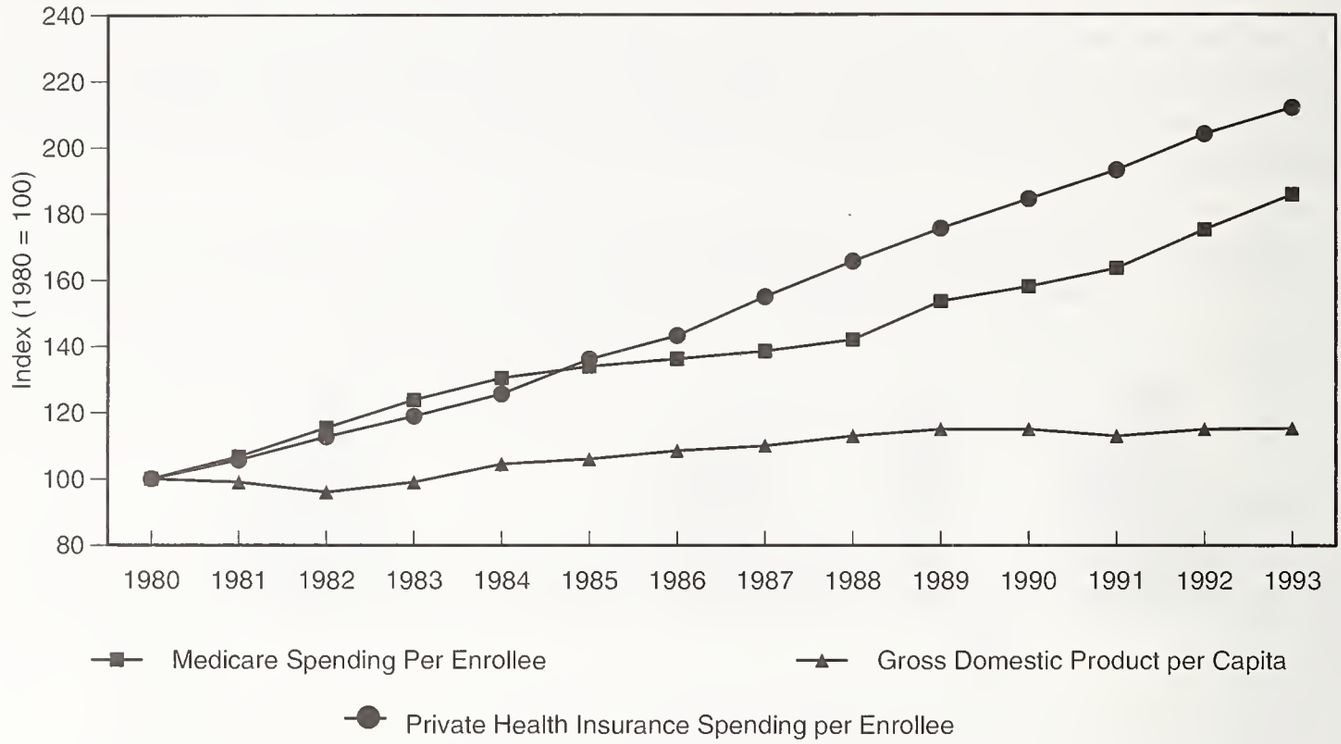
NOTE: Real outlays are in 1991 dollars. Health care outlays exclude those in the Department of Defense.

Medicare and the Private Sector

The rate of growth in Medicare spending is also of concern when compared with growth rates in the private sector (Figure 1-2). During the late 1980s, private spending was rising faster than Medicare at an average annual rate of 9.7 percent per capita compared with 8.4 percent for Medicare. Since then, this trend appears

to have reversed, with private-sector growth rates now below those for Medicare. For example, between 1992 and 1993, private spending per capita increased 7.1 percent, while Medicare's rate was 9.3 percent (Levit 1996). The Congressional Budget Office has projected a continuing differential with private spending experiencing average annual growth rates of 6.9 percent in 2000 and 6.4 percent in 2005.[1]

Figure 1-2. Trends in per Enrollee Expenditures for Medicare and Private Health Insurance and Gross Domestic Product per Capita, 1980-1993



SOURCE: Physician Payment Review Commission analysis of information compiled from the Health Care Financing Administration and the Congressional Budget Office.

NOTE: Values have been adjusted for inflation and are expressed in 1980 dollars.

Industry surveys also report unusually low premium growth during the 1990s. For the first time in a decade, 1995 premium increases for private insurance fell below the rate of general inflation at 2.1 percent for all types of health insurance. Increases ranged from 0.4 percent for health maintenance organizations (HMOs) to 2.7 percent for conventional indemnity products (KPMG Peat Marwick 1995).[2]

The differential in growth rates between Medicare and the private sector can be interpreted in several ways. Lower rates of increase in the private sector may reflect success in creating incentives for more cost-

[1] These numbers are not directly comparable to the growth rates for Medicare mentioned above, because they are not stated as per capita rates.

[2] The Foster Higgins employer survey found only a 0.2 percent increase in private health benefits between 1994 and 1995 but retiree health costs rose 10.5 percent (Foster Higgins 1996).

effective approaches to medical care. Therefore some suggest that Medicare might benefit from adopting these innovations. Others, pointing to Medicare's lower growth rates in the 1980s, suggest that the private sector is only now adopting the strategies already initiated by Medicare such as paying discounted fees to doctors and hospitals. Thus one should look at the level of expenditures, not just growth rates.

Care needs to be taken in comparing private sector and Medicare growth rates. First, comparisons should be made at the per capita level so that they do not reflect changes in the number of people insured. During the 1990s, the number of Medicare beneficiaries has been growing at 1 percent to 2 percent annually. By contrast, between 1988 and 1993, the number of people with employer-provided health insurance dropped by almost 6 percent (Holahan et al. 1995). Second, Medicare does not have the flexibility exercised by private employers to reduce benefits and increase beneficiary cost sharing as a means of lowering spending growth (Davis and Burner 1995). While these strategies may account for some of the slowdown in private-sector growth, such changes could be made in Medicare only through legislation.

In any case, it is also unclear whether private-sector spending has permanently slowed. Over short periods, health spending is quite volatile. Thus it will be some time before it is clear whether the dip in private spending signals the start of a long-term trend.

Policy Directions

Legislation passed by the Congress in November 1995 (H.R. 2491) includes several mechanisms for holding down rates of growth in Medicare spending. Under the fee-for-service program, changes are made in payment policies specific to different sectors. For example, provisions would affect the annual update in hospital payments, the definition of costs used in determining payments to skilled nursing facilities, and payment amounts for durable medical equipment. Under the managed-care program, the method for setting capitation payments would be decoupled from the fee-for-service experience, with rates of growth defined in the legislation. Finally, a failsafe budget mechanism would make further cuts in fee-for-service payments if targeted savings for the entire program (both fee for service and managed care) are not achieved.

THE CHANGING HEALTH CARE MARKET

Policymakers also have their eyes on the rapidly changing health care marketplace. The segment of the population covered by traditional indemnity insurance is shrinking. Managed-care plans are evolving toward more integrated systems and closer relationships with their provider networks, while physicians and hospitals are joining together in new types of organizations. And leading corporate purchasers of health care are changing the way they purchase health services, potentially affecting both the costs and quality of care.

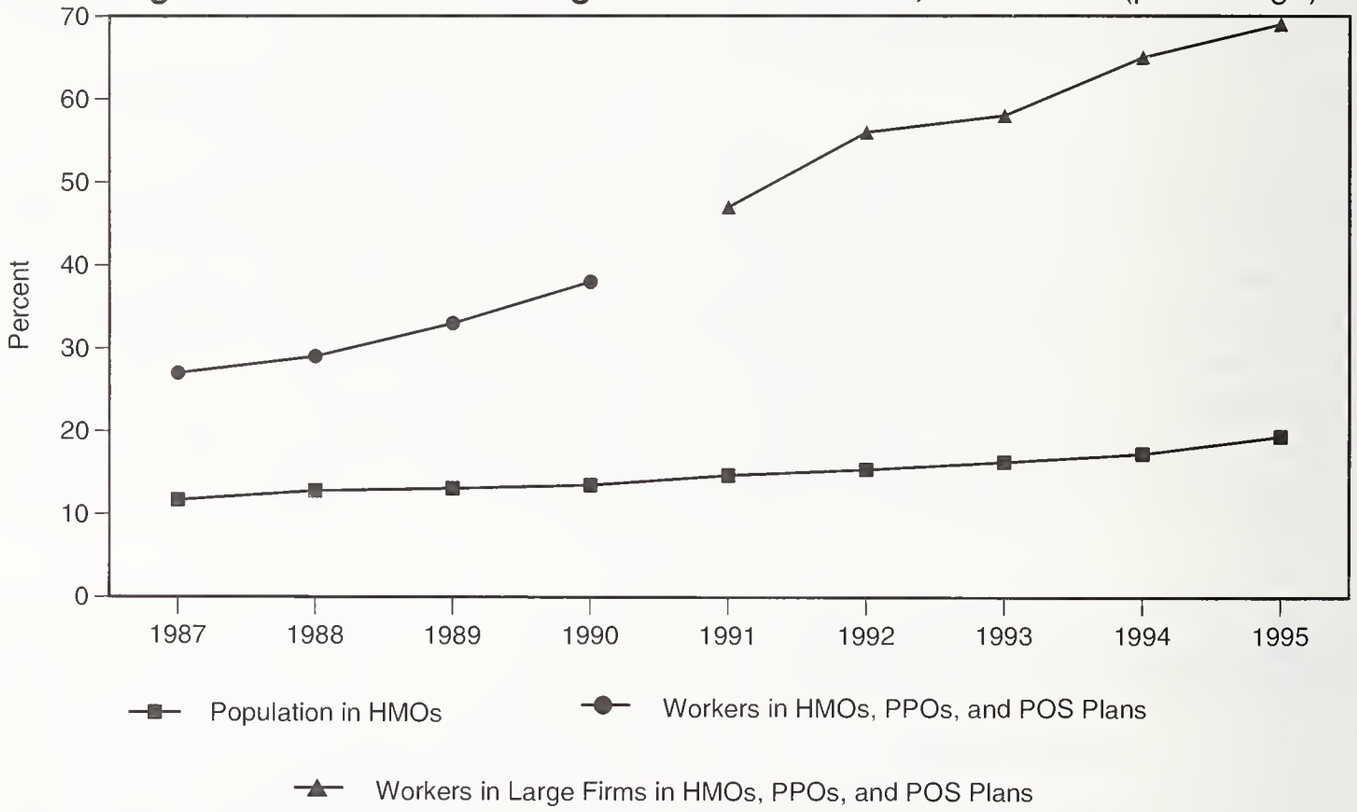
These innovations in the private sector suggest new approaches to the problems with which policymakers have long struggled. But the pace of change varies widely around the country with changes in plan-

provider relationships, mergers, and delivery systems most pronounced in markets such as southern California and Minneapolis-St. Paul. But even in markets thought of as slower to change, new alliances are forming and new managed-care plans are appearing. This diversity suggests the need for policies sufficiently flexible to be applied across markets.

Growth of Managed Care

Managed-care enrollment is growing, continuing its steady rise over the past 15 years (Figure 1-3). More than 19 percent of Americans were enrolled in HMOs in 1995 (InterStudy 1995). Using a definition of managed care that includes preferred provider organizations (PPOs) and point-of-service (POS) plans as well as HMOs, 69 percent of insured workers in firms with 200 or more employees were in managed care in 1995, including 29 percent in HMOs, 22 percent in PPOs, and 18 percent in POS plans (KPMG Peat Marwick 1995). Growth is occurring fastest in some regions (such as the Northeast) and in newer types of plans (for example, point-of-service plans). In rural areas, managed-care penetration remains low, even though it has grown significantly.

Figure 1-3. Trends in Managed-Care Enrollment, 1987-1995 (percentage)



SOURCE: InterStudy 1991, 1995; Hoy et al. 1991; KPMG Peat Marwick 1995.

NOTE: Data for workers in HMOs, PPOs, and POS plans are represented by two different sources; data for 1987-1990 cover all firms, and data for 1991-1995 cover only large firms. Based on one study (Gabel et al. 1994) that supplemented the large firm survey with smaller firms, the estimated percentage of all workers in managed care for 1993 is about 7 percentage points lower. PPO refers to a preferred provider organization, and POS refers to point of service.

Managed-care enrollment among the Medicare population has been growing but remains modest relative to the private sector. In 1995, almost 11 percent of Medicare beneficiaries were enrolled in HMOs, up from slightly less than 6 percent in 1991. Enrollment rates vary considerably across the country. Although 74 percent of Medicare beneficiaries now live in an area with a Medicare managed-care plan available to them, higher rates of enrollment tend to occur where either commercial HMO penetration or Medicare payments are high (e.g., Arizona, California, Florida, Nevada, and Oregon).

The number of managed-care plans participating in Medicare has also grown. In 1995, 154 plans had Medicare contracts, a 41 percent increase over the previous year (HCFA 1995b). About 75 percent of Medicare HMO enrollees are in plans with risk contracts, which are paid on a per capita basis; the rest are in plans with cost contracts that are paid based on reasonable costs.

Further increases in enrollment will depend upon the capacity of HMOs to accommodate elderly and disabled patients and plans' willingness to do business with the Medicare program. Beneficiaries' willingness to receive care under these arrangements will also affect enrollment although this may increase naturally over time as people with managed-care experience age into the program.[3]

Proliferation and Development of New Forms of Delivery Systems

The managed-care world is growing and changing so rapidly that many of its terms are losing their descriptive power. Terms like HMO and PPO have entered into the vernacular (and in fact have been written into state laws), but the distinctions between plan types have become blurred. Conventional insurers, such as Blue Cross Blue Shield Plans, are creating preferred provider networks by using their existing participating provider networks as a first step toward building consumer acceptance of a more limited panel of providers. Some PPOs are starting to accept financial risk to survive in the changing market. In addition, some independent practice association (IPA) plans are moving toward a more integrated structure as commercial insurers seek to position themselves as managed-care companies. As a result, network and IPA HMOs are becoming harder to distinguish from group-model and staff-model HMOs.

Providers are also moving toward greater integration, with physicians, hospitals, and others joining together to create new delivery systems. Relatively little is known about the number and size of these arrangements, however, or their impact on the costs or quality of care. They may be transitory organizations that will eventually become indistinguishable from HMOs. Alternatively, they may remain important distinct entities that work in partnership with health plans.

Many of these developments have not been introduced into the Medicare program. Although new guidelines have recently been released to permit plans with Medicare risk contracts to offer point-of-service products, beneficiaries are typically faced with a choice of traditional fee-for-service coverage or an HMO. Nonetheless, both the Congress and the Administration are supportive of expanding choices,

[3] Preliminary enrollment and plan participation figures for early 1996 suggest that these are increasing rapidly.

giving Medicare beneficiaries a range of insurance options comparable to those employers provide to their employees. But there are substantial differences of opinion about the design of such a system. Key policy issues include the number and types of plans that will be available, whether beneficiaries will have the option to enroll at any point during the year (as under current law) or only during an open season period, the types of information needed to support the choice process, and how quality of care and plan performance will be assessed.

Also at issue is how transferrable the experience of the private sector is to the Medicare program. Medicare differs from employers on a number of dimensions. First, with its 37 million beneficiaries, Medicare is far larger than any employer plan. Even the Federal Employees Health Benefits Program covers only 9 million lives. Second, the Medicare population includes a higher proportion of people with limited incomes, disabilities, or special health needs. Third, compared with Medicare, employers have relatively intimate relationships with their active workers and retirees; that is, they have institutional mechanisms of communication and a captive audience.

New Roles for Purchasers

Concern about rising health costs, including growing expenditures for retirees, have led many employers to take more aggressive steps in purchasing health insurance. Some large employers have become more active purchasers on their own while smaller firms are joining with other companies as part of business coalitions.

Purchasers are pursuing a range of strategies targeted both at reducing premiums and at improving the value of the products they offer to employees. These strategies include providing incentives to employees to select managed-care options, negotiating for lower increases or reductions in premiums, implementing competitive bidding for plan contracts, setting standards related to quality and access, and direct contracting with providers.

There are conflicting views about what Medicare can learn from these experiences. Medicare could act like an employer purchasing for a group and narrow the choices available to beneficiaries to a selected set of options. Because of its size, Medicare has substantial market power. If given the ability to act as an aggressive purchaser, Medicare has considerable potential to gain savings for the program, improve plan performance on behalf of beneficiaries, and influence changes in the delivery of medical care systemwide. This potential is threatening, however, to those who fear that Medicare might take the health system in the wrong direction.

Also at issue is whether Medicare could act as quickly and aggressively as other purchasers. What employers can accomplish through contracting and negotiation, the Medicare program must do with the much slower processes of legislation and rulemaking. Unresolved as well is the potential conflict between Medicare's role as purchaser with respect to the managed-care sector while acting as a payer for the fee-for-service program.

ENHANCING THE PERFORMANCE OF THE MEDICARE PROGRAM

Another factor motivating Medicare reform is the need to enhance performance under fee for service (still the predominant form of payment under the program and the option chosen by almost 90 percent of beneficiaries) as well as under the risk-contracting program. Even without legislation, the growth of Medicare managed-care enrollment raises several important policy issues relevant to both fee for service and managed care.

Program Performance under Fee-for-Service Medicare

The Commission's analyses of the traditional Medicare program have focused primarily on physicians' services. Under OBRA89, payments to physicians are based on a relative value scale consisting of three components:

- a physician work component that reflects the time and intensity of the physician's effort in providing a service;
- a practice expense component that includes costs such as office rent, nonphysician salaries, equipment, and supplies; and
- a separate malpractice component that reflects premium expenses for professional liability insurance.

This relative value scale is translated into a schedule of fees when the sum of the three components is multiplied by a monetary conversion factor. A geographic adjustment factor is also applied to each of the components to allow fees to vary from one locality to another, reflecting differences in the costs of practicing medicine. Conversion factors are updated annually as part of the volume performance standards process under which expenditure growth is compared with performance standards set two years earlier.

Since the passage of OBRA89, payment policy for physicians' services has continued to evolve, both through legislation and regulation. With respect to the fee schedule, current policy issues include implementation of resource-based practice expense relative values, the five-year review of relative values for physician work, and new ways of defining the geographic areas across which payments may vary.

Policy development concerning the VPS has focused on several problems. First, limitations in the formula now used to set updates will result in substantial reductions in the conversion factor over the next five years. Second, the existence of three performance standards is introducing serious distortions in the patterns of relative payment, the very problem the Medicare Fee Schedule was intended to correct (Table 1-1).

Table 1-1. Conversion Factors, by Category of Service, 1992-1996 (dollars)

Category of Service	1992	1993	1994	1995	1996
All Services	$31.00	-	-	-	-
Surgical Services	-	$31.96	-	-	-
Nonsurgical Services	-	31.25	-	-	-
Surgical Services	-	-	$35.16	$39.45	$40.80*
Primary Care Services	-	-	33.72	36.38	35.42*
Other Nonsurgical Services	-	-	32.90	34.62	34.63*

SOURCE: Physician Payment Review Commission compilation of conversion factors as reported in the *Federal Register.*

* These conversion factors include an additional 0.36 percent reduction due to a budget-neutrality adjustment. This adjustment offsets increases in spending from changes to the relative value units and other payment policy changes for 1996.

In addition to addressing problems with payment policy, the traditional Medicare program might also be strengthened by the introduction of additional techniques to control costs and improve the quality of care. The extent to which Medicare can or should adopt private-sector practices for controlling utilization and managing care is unclear.

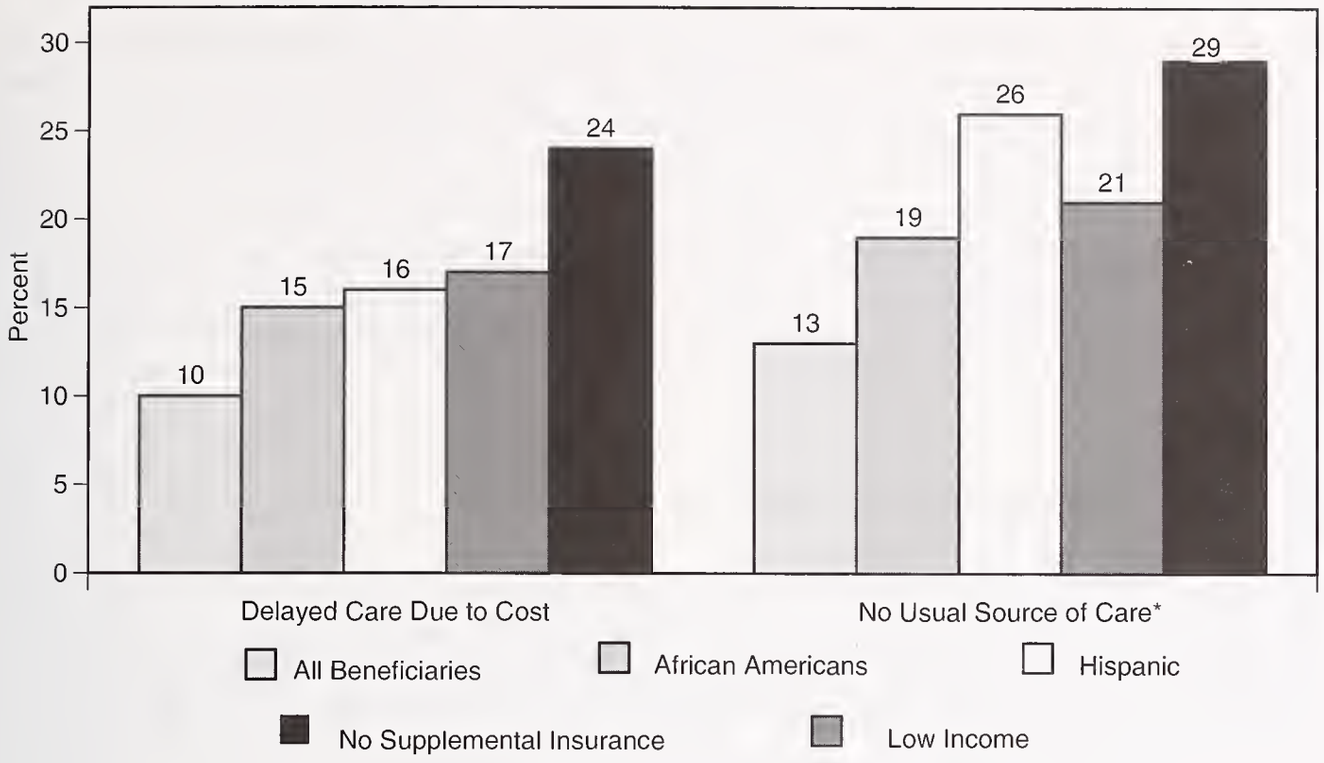
Finally, although access for most beneficiaries has remained good throughout the transition to payment under the fee schedule, the Commission continues to be concerned about barriers to access that face Medicare's most vulnerable beneficiaries, including the poor, the disabled, and minorities. These populations are more likely to delay care due to costs, are less likely to have a usual source of care, use fewer physicians' services, are more likely to receive care in the emergency room, and have poorer health outcomes (Figure 1-4).

Program Performance under Medicare Managed Care

Proposed legislation to broaden Medicare's managed-care program has highlighted some of the problems in existing policies. But even without major restructuring, policies related to payment, quality assurance, and access monitoring all merit attention. Moreover, each of these issues points to the need for improved availability of the data required to monitor and enhance program performance.

Medicare capitation payments to managed-care plans are now based on a percentage of expected fee-for-service payments per enrollee in a given geographic area (referred to as the adjusted average per capita cost or AAPCC). Problems with this method include wide geographic variation in payment rates due to local variations in fee-for-service patterns of use; volatility of county-level payment rates, particularly for those counties with small Medicare populations; inclusion of medical education and disproportionate share hospital payments that may not reflect plan use of hospitals receiving these payments; and limits on Medicare's ability to recapture cost savings achieved by participating health plans. In addition, the current risk adjustment of the AAPCC captures only a small fraction of differences in enrollees' health care costs.

Figure 1-4. Medicare Beneficiaries Reporting Problems with Access, 1993 (percentage)



SOURCE: Physician Payment Review Commission analyses of 1993 Medicare Current Beneficiary Survey.

* Usual source defined as identifying a physician's office or a particular physician as a usual source of care.

These problems can be corrected in two ways—within the framework of AAPCC-based payments or by decoupling payments from fee-for-service expenditures altogether.

Growth in managed-care enrollment also creates urgency to reconsider methods for ensuring quality and monitoring access. Differences in plan design and in the types of data available under fee-for-service versus capitated payment may necessitate different strategies for quality assurance. Monitoring access within managed care also presents a new set of challenges for Medicare; changes in utilization from fee-for-service levels may represent improvements in primary care and care coordination or result from barriers to necessary care. Because encounter data are not yet available, initial monitoring may have to rely on surveys. Attention also must be paid to identifying groups that may be vulnerable to access problems in managed-care settings.

Cross-Cutting Issues

Efforts to enhance the performance of fee for service may directly affect the managed-care program and vice versa. This becomes apparent under two circumstances. First, some similar policy questions affect both programs, for example, determining the geographic areas within which a common payment level should prevail. While the same area definitions do not need to be used in both fee for service and managed

care (as in fact they are not under current law), these decisions should be determined based on common principles.

Second, certain policy decisions affecting one aspect of the program may have unintended consequences for the other. For example, under the current method for setting capitation payments, any changes affecting fee-for-service expenditures will influence payment rates. Similarly, under the failsafe provision of the congressional conference agreement, assumptions about managed-care enrollment patterns potentially affect the level of fees paid to providers under fee for service. Moreover, strategies to adjust for risk selection (the extent to which people with higher or lower than average service use because of health status select certain insurance options) must be designed with two types of selection in mind—among managed-care plans, and across the managed-care and fee-for-service programs. These relationships will challenge policymakers as they strive to develop effective mechanisms for improving the Medicare program.

ISSUES AFFECTING THE MEDICAID PROGRAM

Since its inception in 1965, Medicaid has substantially improved access to health services for its beneficiaries. Previously, many of the poor went without care. By the late 1970s, the Medicaid program had been largely successful in increasing access to health care services and improving the health status of its beneficiaries (Davis and Schoen 1978; Davis and Reynolds 1976). When beneficiaries' eligibility for Medicaid terminates or when there are program cuts, access to care diminishes and health status deteriorates (Lurie et al. 1984; Lurie et al. 1986). When Arizona did not have a Medicaid program, for instance, poor children saw physicians 40 percent less often than poor children in other states (Blendon et al. 1986).

Medicaid beneficiaries have better access than the uninsured but not as good as the privately insured.[4] For example, sick newborns with Medicaid received more hospital resources than those without insurance (Braveman et al. 1991). At the same time, Medicaid patients were more likely than the privately insured to be admitted to the hospital for avoidable conditions (Weissman et al. 1992).

Despite substantial improvements in health care for the poor, the Medicaid program has been criticized along several lines. The major criticisms include the lack of coverage for all the poor, considerable growth in program costs, and federal direction of the program.

By design, Medicaid does not provide insurance coverage for all the poor. In 1993, 43 percent of those below poverty were covered solely by Medicaid, 5 percent were dually eligible for Medicaid and Medicare, 8 percent were eligible for Medicare, 16 percent were covered by other insurance, and 29 percent were uninsured (HCFA 1995c).[5] Moreover, the proportion of the poor covered by the program varies by state. For example, between 1990 and 1992, Nevada covered slightly under 29 percent of the nonelderly poor, while the District of Columbia covered over 60 percent (Kaiser Commission on the Future of Medicaid 1995).

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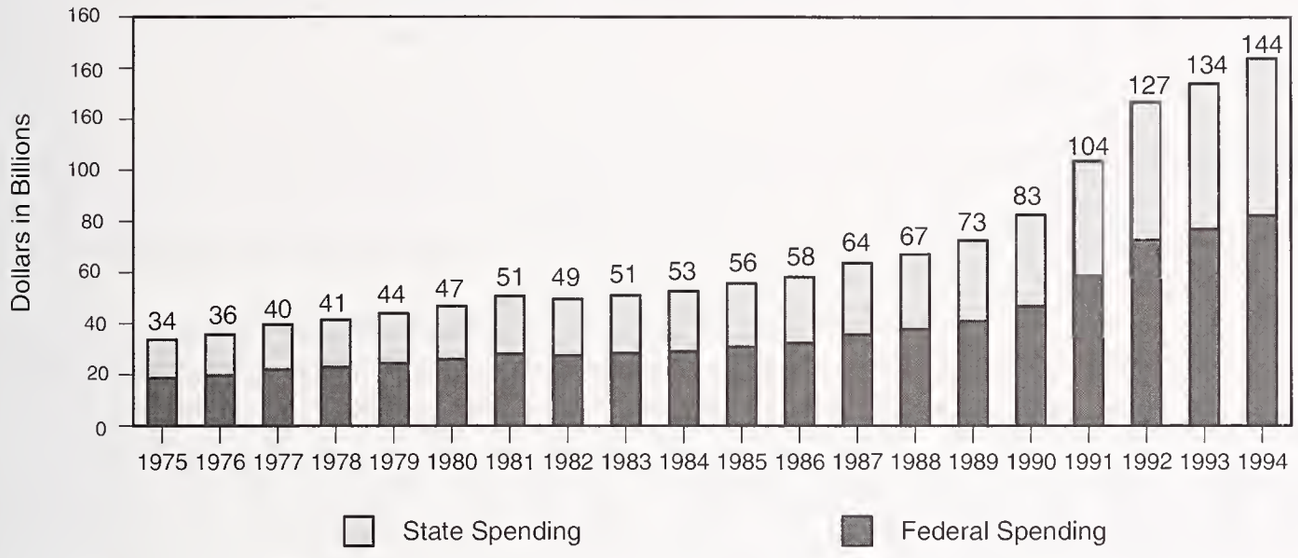
[4] There are exceptions to this general finding. For example, Medicaid patients and the uninsured had similar odds of receiving angiography and bypass surgery (Wenneker et al. 1990).

[5] For more information see Table 19-1 in Chapter 19.

Growth in program expenditures has been a major impetus for proposals to restructure the program. Total expenditures for Medicaid have more than quadrupled in real terms since 1975 (HCFA 1995c) (Figure 1-5). In 1994 dollars, federal expenditures grew from $19 billion in 1975 to $82 billion in 1993; state expenditures rose from $15 billion to $66 billion during the same period. Medicaid constitutes about 6 percent of the federal budget and 20 percent of state budgets. In addition, Medicaid accounted for about 42 percent of all federal funds going to states in 1994, up from about 14 percent in 1975 (National Association of State Budget Officers 1995; HCFA 1995c).

Figure 1-5. Total Federal and State Medicaid Expenditures, 1975-1994



SOURCE: Physician Payment Review Commission analysis of information compiled from the Health Care Financing Administration and the Congressional Budget Office.

NOTE: Values have been adjusted for inflation and are expressed in 1994 dollars.

A third criticism is that the program lacks flexibility to respond to unique needs of states. State officials complain that federal mandates, especially those passed after 1988, have exacerbated state financial crises and do not allow for state responses to their unique needs. In July 1989 the National Governors Association called for a moratorium on further mandates.

CONCLUSIONS

As this report goes to press, the Congress and the Administration remain at an impasse over both the magnitude of desired Medicare and Medicaid savings and many key design issues related to broadening insurance options within the Medicare program and restructuring Medicaid. The analyses and recommendations presented here should remain salient, however, in informing this debate no matter how it is resolved.

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Expanding Plan Options for Medicare Beneficiaries

For more than a decade, some Medicare beneficiaries have had the option of selecting private health plans in lieu of receiving health services on a fee-for-service basis through the traditional Medicare program. For a variety of reasons, such options have not been uniformly available around the country and have been selected by only a small minority of all beneficiaries.

In the last few years, enrollment has grown rapidly, although total numbers remain small. In addition, many policymakers are now considering changing Medicare's rules to expand beneficiaries' choices, usually with the ultimate goal of reducing growth in Medicare expenditures. During the first session of the 104th Congress, there was extensive debate over ways to transform Medicare to broaden the array of options available to Medicare beneficiaries and to control costs. Proponents of change differ on the urgency of moving beneficiaries away from traditional Medicare and on the structure of any incentives to induce beneficiaries to make this switch. But there is broad support for expanding options.

This chapter briefly summarizes the choices now available to beneficiaries and provides some baseline data on participation in these options. It then describes the types of options generally available in the private sector but not in Medicare. The chapter finally discusses how a broader array of options might be offered to Medicare beneficiaries, with attention to specific approaches advanced in legislative proposals. This discussion focuses only on private plan options; options for including more management under fee-for-service Medicare are described in Chapter 11. The chapter concludes with comments on a strategy for monitoring the impact of broadening choices for beneficiaries.

This chapter includes:

- *Current managed-care options in Medicare*
- *Data on enrollment trends in Medicare managed care*
- *Potential private plan options in an expanded Medicare*
- *A strategy for monitoring the effects of broader choices in Medicare*

OPTIONS FOR MEDICARE MANAGED CARE UNDER CURRENT LAW

At present, a private health plan has several different ways to become involved with Medicare.[1] First, it can enter into a Medicare risk contract, under which the plan receives capitated payments for the beneficiaries it enrolls. Based on guidelines issued in October 1995, risk contracts may include a point-of-service (POS) option, which allows beneficiaries to use providers outside the plan's network. Second, a plan can enter into a cost contract, under which it is paid on a fee-for-service basis for the reasonable costs of services delivered to its enrollees. Third, plans can offer Medicare SELECT, in which a beneficiary purchases a supplemental insurance (Medigap) policy that links provision of supplemental benefits to use of network providers for standard Medicare benefits. Finally, the Health Care Financing Administration (HCFA) has allowed other arrangements on a demonstration basis, such as social health maintenance organizations, which also receive Medicaid funding and seek to manage care across a broad spectrum of acute and long-term care services. HCFA's most recent demonstration project, known as Medicare Choices, is designed to encourage participation by different types of plans.

Medicare Risk Contracts

Under the risk-contract option, established in its current form in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), health maintenance organizations (HMOs) must offer all Medicare-covered services to beneficiaries for a capitation payment.[2] Most risk-contracting plans also offer supplemental benefits such as coverage for cost sharing or services not otherwise covered by Medicare, and enrollees may be charged an additional premium (above the Part B premium paid to Medicare) for these services. About half of all risk-contract plans charge no additional premium for these services and are referred to as "zero premium plans" (HCFA 1995b).

Under current law for risk contracts, Medicare's capitation payment to the plan is based on an estimate of local fee-for-service costs and is established for each county at 95 percent of the adjusted average per capita cost (AAPCC) for Medicare fee-for-service beneficiaries. Various proposals to modify this approach to payment, including the use of competitive bidding and methods of decoupling payment from fee-for-service expenditures, are discussed in Chapter 5 of this report.

In general, enrollees who select a risk plan are required to use the plan's network of providers and agree to obtain all covered services through the plan, except in emergencies. If the plan authorizes the use of nonnetwork providers, such services are paid by the plan, not by Medicare. Under certain circumstances, plans may also offer a point-of-service option to allow beneficiaries greater use of nonnetwork providers without plan referral.

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[1] In this context, the term "health plan" generally refers to any of the different types of managed health plans, often designated as health maintenance organizations or preferred provider organizations. The term could also refer to private fee-for-service plans, although they cannot be the primary insurers for Medicare beneficiaries at present. The latter may serve as carriers or fiscal intermediaries or may sell supplemental insurance—roles not considered in this chapter.

[2] Plans must either be HMOs that are federally qualified under the HMO Act or competitive medical plans that meet standards in Medicare law. The term HMO in this chapter may refer to either entity.

Enrollees may terminate enrollment at any time, effective on the first day of the month following the month during which the request is filed. Proposals to modify the enrollment and disenrollment rules now in effect are described in Chapter 4.

Under Medicare risk contracts, the plan must normally employ or have contractual relationships with its providers. This provision has been interpreted to mean that at least 50 percent of services must be delivered by employees or subcontractors (CRS 1995). It thus appears that other types of plans, such as preferred provider organizations (PPOs) that permit a majority of services to be delivered by nonnetwork providers, cannot qualify as risk contractors. Provider networks must either be the same or a smaller subset of the networks used for commercial enrollees, and no providers may be restricted to Medicare enrollees only. Providers are paid by the risk-contracting plan out of the capitation it receives from Medicare. Normal Medicare payment policies (e.g., fee schedules) do not necessarily apply, and Medicare does not pay any provider directly for services delivered to risk enrollees.

Medicare Point-of-Service Option

Until recently, point-of-service options were not part of the managed-care arrangements available to Medicare beneficiaries.[3] In October 1995, HCFA set forth clarifying guidelines for risk contractors that seek to offer such an option (HCFA 1995c). By March 1996, risk-contracting plans had submitted 52 proposals to begin offering POS options at some time during the year, with 6 of them already doing so.

In issuing these guidelines, HCFA expects that the POS benefit may encourage more beneficiaries to join managed-care plans. It also noted that the benefit can offer more choices to enrollees who wish to use providers not available in a plan's network or who expect to travel outside their plan's service area.

The HCFA guidelines offer risk contractors several approaches for developing POS options under existing legislative authority that defines how plans can add to Medicare's standard benefit package (HCFA 1995c). Nearly all plans submitting proposals for 1996 chose to offer POS as an optional supplemental benefit, meaning that it would be available for a premium to those enrollees who choose it. Plans are also permitted to offer POS as a mandatory supplemental benefit, which all enrollees would be required to purchase for an additional premium. If the benefit is mandatory, HCFA recommends that the premium be small to avoid discouraging enrollment in the plan. A third option is for the plan to offer the POS benefit as an additional benefit that is provided to all enrollees with no premium charged. It differs from the second approach because it is funded from the accrued savings that the plan must return to beneficiaries in added benefits.[4]

Most of the decisions in developing the benefit structure are left to plans. In the private sector, arrangements vary considerably, in part because these plans are relatively new in most markets. Under a POS option, plans must still make available all Medicare-covered services within the plan. With HCFA's

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[3] One exception was the Health Plan of Nevada, which offered a Medicare POS option on a demonstration basis.

[4] Under Medicare rules, any excess revenue a plan accrues compared with what it would have received if paid private market premiums, adjusted for demographic differences, must be returned to the program or to enrollees, usually in added benefits.

approval, plans can set the rates of coinsurance and deductibles for out-of-plan services. Plans can determine which services would be covered out of plan, can use precertification to approve services, and can set annual dollar limits on the amount of out-of-plan services for which beneficiaries will be covered.

The HCFA guidelines specify that plans can use their own payment mechanisms to pay providers for out-of-plan services, but beneficiaries are still protected by Medicare's limits on balance billing (see Chapter 3). In addition, HCFA's guidelines include several rules that plans must follow in implementing a POS benefit, mostly designed to protect beneficiaries:

- Plans must demonstrate fiscal and administrative capacity to manage the POS benefit and associated costs to ensure that the plan's viability is not threatened.

- Plans must track the services enrollees receive through the POS benefit to ensure continuity of care.

- Enrollees must be clearly informed about POS rules, including the differences between coverage of emergency out-of-area services and out-of-network coverage available only under the POS benefit. Enrollees must also be informed about all costs and possible financial risks associated with using a POS benefit.

Cost Contracts and Health Care Prepayment Plans

Two different types of cost-based contracts exist in Medicare. Health care prepayment plans (HCPPs) were authorized by the original Medicare statute and apply only to Part B services. A second type of cost contract, which covers all Medicare services, was first authorized in 1972, with rules modified under TEFRA. Under both options, beneficiaries enroll with a plan and may pay a premium to obtain supplemental benefits, such as a waiver of coinsurance payments and other cost-sharing amounts. Enrollment in these plans has been substantially surpassed by that in risk-contracting plans in recent years.

Under either arrangement, the plan receives an interim payment based on its own cost estimates; final payment for services rendered is determined in an annual process that compares the amount of interim payments with actual allowable costs for services delivered by plan providers. Medicare pays the plan for the services of network providers (less the estimated value of beneficiary cost sharing), subject to a test of reasonableness.

In contrast to those enrolled in risk contracts, enrollees in cost-contracting plans have an unrestricted option to go out of network. Medicare reimburses nonnetwork providers, using normal Medicare procedures, for services that enrollees choose to obtain from them. For those who purchase coverage of cost sharing as a supplemental benefit, their financial incentive to stay in the network is that the plan will pay these costs.

Medicare SELECT

Medicare SELECT plans offer a network-based supplemental insurance policy that provides coverage for Medicare cost sharing. Medicare SELECT was created as a demonstration project in 1990 to offer beneficiaries in up to 15 states a new Medigap insurance option. In 1995, it was authorized to expand to all states, and it could be made permanent in 1998.

Under Medicare SELECT, there is no specific contractual relationship between Medicare and the network plan. Enrollees who purchase a Medicare SELECT plan receive supplemental benefits, generally to the extent that they use preferred providers in the plan's network. Typically, services will be paid in full if preferred providers are used (with Medicare paying its usual portion and the SELECT plan paying the beneficiary's cost sharing). To the extent networks are in place, cost sharing is not paid in full if the beneficiary uses a nonnetwork provider, although Medicare still pays its portion of the bill to the provider.[5]

Medicare Choices Demonstration Project

In June 1995, HCFA announced the Medicare Choices demonstration project, designed to offer flexibility in contracting requirements and payment methods for health plans and other organized delivery systems that wish to participate in Medicare. Its broader purpose was to test beneficiaries' response to a range of health care delivery system options and to evaluate their suitability for Medicare. The request for proposals explicitly encouraged a variety of organizations in addition to traditional HMOs to submit applications, and it sought applications from several markets where Medicare managed-care participation was relatively low (HCFA 1995a).

A total of 372 organizations submitted preliminary letters of interest, of which 52 were invited to submit full proposals. Responses were received from 37 organizations.[6] The finalists are concentrated in seven urban markets and rural areas in several states; a substantial number are provider-sponsored organizations. Decisions on the winning plans are expected by April 1996.

ENROLLMENT TRENDS FOR MEDICARE MANAGED CARE

Historically, a relatively small percentage of Medicare beneficiaries have enrolled in private health plans, but the numbers have risen steadily in the past several years. This section presents some data on participation in the different types of Medicare private plans, including information on the characteristics of enrollees and the pattern of concentration in a few states.

Total enrollment in Medicare risk and cost plans rose to 10.7 percent of all beneficiaries in 1995 (Table 2-1). The largest numbers and all of the growth have been in risk plans, which increased from 3.8 percent in

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[5] See Chapter 16 for a more in-depth discussion of Medicare SELECT.

[6] Some nonrespondents dropped out because they had intended to offer POS options; their proposals became unnecessary when HCFA issued guidelines allowing all plans to offer POS options.

Table 2-1. Enrollment Rates for Medicare Risk-Contract and Cost-Contract Plans, 1991-1995 (percentage)

Type of Plan	1991	1992	1993	1994	1995
Risk-Contract Plans	3.8%	4.4%	5.3%	6.6%	8.8%
Cost-Contract Plans	2.1	2.2	2.4	2.1	1.9
Total	5.9	6.6	7.7	8.7	10.7

SOURCE: Physician Payment Review Commission analysis of year-end enrollments for each year from the Managed Care Contract Reports published by the Office of Managed Care, Health Care Financing Administration.

1991 to 8.8 percent in 1995; enrollment rose by one-third just from 1994 to 1995. By contrast, enrollment in cost-contracting plans fell to a low of 1.9 percent in 1995. If Medicare SELECT beneficiaries are added to the total, enrollment in any type of Medicare managed care was 12 percent in 1995. About 1.3 percent of all beneficiaries were in Medicare SELECT plans at the end of 1995, accounting for 2.8 percent of beneficiaries in the 14 states where these were available.

Although many beneficiaries join health plans at the time of Medicare eligibility or soon thereafter, a substantial fraction wait for one or more years before choosing this option. Of beneficiaries who enrolled for the first time in 1994, an estimated 14.7 percent joined a plan in their first month of entitlement. A total of about one-fourth of the new enrollees joined in their first three months. By contrast, about 60 percent waited longer than a year to enroll. The trend since 1992 indicates that a somewhat larger proportion of beneficiaries are waiting this long than had in previous years. In 1992, only about 55 percent of new enrollees waited longer than a year to enroll (Table 2-2).

The simultaneous trends of rapidly rising enrollment and longer waits before enrollment imply that both newly entitled beneficiaries and those who have been in the program for a year or more are enrolling in growing numbers, but that growth has been faster for the latter group. The overall pattern of higher enrollments is a predictable result of increased market penetration by managed care in many areas of the country. New Medicare beneficiaries should be more familiar with managed-care options, because many of

Table 2-2. Time Elapsed between Medicare Entitlement and Enrollment in Medicare Risk-Contract and Cost-Contract Plans by Beneficiaries, 1992-1994 (percentage of new enrollees)

Time from Medicare Entitlement until Plan Enrollment	1992	1993	1994
Same Month	17.1%	15.4%	14.7%
1 to 3 Months	11.7	9.9	9.1
4 to 6 Months	3.8	3.5	3.1
7 to 12 Months	12.9	12.6	12.8
Longer than 12 Months	54.6	58.7	60.2

SOURCE: Physician Payment Review Commission analysis of Medicare enrollment files for the 5 percent sample of beneficiaries for 1991 through 1994.

them have had HMO coverage before becoming eligible for Medicare. At the same time, the rising number of plans joining the program provides new opportunities for other beneficiaries, especially in local markets where Medicare managed-care penetration has been low.

Characteristics of Medicare Health Plan Enrollees

Medicare beneficiaries who are enrolled in health plans differ somewhat from their fee-for-service counterparts, and new enrollees in a given year differ from those who already are enrolled at the beginning of the year. This section describes the characteristics of plan enrollees, comparing them with fee-for-service beneficiaries.

Among those beneficiaries who are 65 or older, HMO enrollees are about the same age as fee-for-service beneficiaries (Table 2-3). Beneficiaries who participate in Medicare because of their disability status and are by definition under 65 years old represent a disproportionately small share of HMO enrollment. In 1994, only 4.5 percent of HMO enrollees, compared with 11.6 percent of fee-for-service beneficiaries, were entitled based on disability. The combination of these two results means that, although there is an overall age difference between HMO enrollees and those in traditional Medicare, the difference simply reflects the smaller share of HMO enrollees who are entitled to coverage owing to disability.

HMO enrollees also differ from fee-for-service beneficiaries by race (Table 2-3). African Americans were only 6.7 percent of HMO enrollees in 1994, compared with 9.1 percent of fee-for-service beneficiaries. On the other hand, greater proportions of other racial groups were enrolled in HMOs (5.7 percent versus 3.7

Table 2-3. Characteristics of Medicare HMO Enrollees, Compared with Other Beneficiaries, 1994 (percentage)

	Fee-for-Service Beneficiaries	All HMO Enrollees	New HMO Enrollees
Average Age (years)			
All beneficiaries	70.9	73.6	70.0
Beneficiaries 65 years or older	74.1	74.4	71.4
Female Beneficiaries	57.1%	56.9%	55.4%
Race			
White	86.1%	86.6%	82.8%
African American	9.1	6.7	7.7
Other	3.7	5.7	6.9
Unknown	1.1	1.0	2.6
Medicare Status			
Old age	87.7%	95.2%	90.0%
Disability	11.6	4.5	9.8
End-stage renal disease	0.7	0.2	0.2

SOURCE: Physician Payment Review Commission analysis of Medicare enrollment files for the 5 percent sample of beneficiaries for 1994.

NOTE: New enrollees are those enrolling in HMOs for the first time in 1994.

percent), possibly reflecting the higher proportion of Asian Americans and Hispanics in the high-enrollment states of California and Florida.

Observable differences between new enrollees and all HMO enrollees indicate that the HMO enrollee mix is changing. Compared with earlier years, greater proportions of new enrollees in 1994 were nonwhite or disabled beneficiaries (Table 2-3).

Enrollment data offer only limited information on how HMO enrollees compare with their fee-for-service counterparts. Even if the two groups were identical by age, sex, race, and Medicare eligibility status, they may differ in other factors such as socioeconomic status or health status. Survey data or claims data would be needed to provide information on these factors (see Chapter 15).

Enrollment Patterns for High Enrollment States

Enrollment in health plans is concentrated in urban areas and in a small set of states. A total of 17 states had at least 1 percent of total Medicare HMO enrollment in 1995, and they accounted for more than 90 percent of all enrollees (Table 2-4). Almost 50 percent of enrollees lived in just two of these states, California and Florida. The same 17 states also accounted for virtually an identical share of newly enrolled beneficiaries.

Table 2-4. Enrollment in Medicare Risk-Contract and Cost-Contract HMOs for States with at Least 1 Percent of Enrollment, 1995 (percentage)

State	HMO Enrollees as Share of National HMO Enrollment	HMO Enrollees as Proportion of All Beneficiaries in State
California	35.5%	33.3%
Florida	12.5	16.4
New York	5.9	7.6
Arizona	5.0	28.7
Oregon	4.2	30.4
Texas	4.1	6.7
Pennsylvania	3.7	6.2
Minnesota	3.4	18.7
Washington	3.0	15.1
Illinois	2.9	6.0
Massachusetts	2.5	9.1
Colorado	2.4	19.8
Ohio	1.4	2.8
Hawaii	1.3	30.3
Nevada	1.2	22.3
New Jersey	1.2	3.6
Missouri	1.0	4.1

SOURCE: Physician Payment Review Commission analysis of summary files from the Medicare group health plan master file for mid-1995.

NOTE: The 17 states with at least 1 percent of enrollment include 91.2 percent of total U.S. enrollment. Enrollment in these 17 states is 13.9 percent of the beneficiaries in those states, compared with 9.3 percent nationally for mid-1995.

Rates of enrollment vary widely, however, among the states (Table 2-4). In four states (Arizona, California, Hawaii, and Oregon), more than one-fourth of the beneficiaries were enrolled in HMOs in 1995. Among the 17 states with the most enrollees, the range was from 33.3 percent in California to 2.8 percent in Ohio. Across the country, 18 states had enrollment rates below 2 percent.

For the most part, the patterns of enrollment in risk plans are not especially different from those for total enrollment in risk and cost plans. Risk enrollment is similarly concentrated; in fact, at the county level, 82 percent of all risk enrollees lived in only 45 of 3,246 counties (Palsbo 1996). But there are some significant differences among the states in the percentage of their HMO enrollees who are in risk plans as opposed to cost contracts or HCPPs (Table 2-5). Four states (Arizona, Florida, Nevada, and Washington) had more than 90 percent of their HMO enrollees in risk-contracting plans. By contrast, three states (of the top 17) had fewer than half of their HMO enrollees in risk contracts. For example, only 48.6 percent of Minnesota's HMO enrollees are in risk plans, probably because of the relatively low payment rates in that state.

MANAGED-CARE OPTIONS IN THE PRIVATE SECTOR

In many cases, private-sector employees have more choices and a broader variety of options than Medicare beneficiaries. Choice in the private sector generally grew in the 1970s and 1980s as corporate purchasers added managed-care options for their employees and gave them incentives to select these plans. After some employers moved to streamline their options, the most recent trends show that the number and types of plans being offered to each worker are growing. Furthermore, private-sector workers have selected managed-care plans at much higher rates than have Medicare beneficiaries. Almost 70 percent of insured workers in large firms were in managed care in 1995, compared with about 11 percent of Medicare beneficiaries (KPMG Peat Marwick 1995).

Table 2-5. Enrollment in Risk Plans as a Proportion of Total Medicare HMO Enrollment, for States with at Least 1 Percent of Enrollment, 1995 (percentage)

State	Proportion of All Enrollees	State	Proportion of All Enrollees
California	87.1%	Illinois	76.0%
Florida	97.5	Massachusetts	74.9
New York	62.6	Colorado	74.3
Arizona	99.2	Ohio	57.6
Oregon	67.0	Hawaii	29.5
Texas	87.9	Nevada	92.8
Pennsylvania	84.5	New Jersey	38.7
Minnesota	48.6	Missouri	55.5
Washington	90.1		

SOURCE: Physician Payment Review Commission analysis of summary files from the Medicare group health plan master file for mid-1995.

NOTE: States are sorted by share of national HMO enrollment.

The amount of choice, however, does vary by firm size. Workers in the largest firms were more likely to have at least some choice in 1995 (88 percent in firms of 5,000 or more workers; 74 percent in firms of 1,000 to 5,000 workers). Only 54 percent of employees in firms of 200 to 1,000 had choice, and the number is likely even lower for the smallest firms (KPMG Peat Marwick 1995). In 1993, about 60 percent of those in businesses with fewer than 50 workers could get only conventional (nonmanaged) insurance (Morrisey et al. 1994).

Although Medicare options have been expanding in at least some parts of the country, the breadth of plan options in the private sector generally remains greater than in Medicare. Plans can be categorized along different dimensions. The usual categorization of managed-care plans emphasizes the ways that plans themselves relate to their network providers. It generally distinguishes a group-model or staff-model HMO (where physicians typically have exclusive relationships with the plan) from an independent practice association or network HMO (where physicians, in groups or individually, contract with the plan for only a portion of their practice). It also separates all types of HMOs from PPOs (where physicians may agree to no more than accepting the plan's fee schedule). These categories are becoming less salient as insurers and managed-care companies offer new products and modify old ones in response to purchasers' demands.[7]

An alternative typology may be more relevant to understanding the relationships of plans to purchasers and enrollees. It is similar to one developed by Gold and her colleagues in their report on the Commission-sponsored survey of managed-care plans (Gold et al. 1995). The typology is based on two factors: whether plans are at risk and whether enrollees are locked into using only network providers (Table 2-6).

The purchaser's perspective is highlighted by looking at whether plans are put fully at risk (Table 2-6). Smaller employers are more likely to transfer full risk to the plan with which they contract. Larger

Table 2-6. Typology of Health Plan Options

	Plan at Full Risk	Plan Not at Full Risk
Enrollees Locked In	The purchaser contracts with a health plan (typically an HMO) for a fixed per person payment, thus transferring all financial risk to the plan. Enrollees may only use the plan's designated network of providers.	The purchaser (typically a self-insuring large firm) contracts with a health plan that requires enrollees to use only network providers. The purchaser retains some or all of the risk for the use of services.
Enrollees Not Locked In	The purchaser contracts with a health plan (typically a point-of-service HMO or PPO) that permits enrollees, in at least some circumstances, to use nonnetwork providers. The plan remains at full risk for both in-network and out-of-network services (subject to beneficiary cost sharing).	The purchaser contracts with a health plan (typically a PPO or fee-for-service plan) that allows enrollees to use nonnetwork providers. The purchaser retains some or all of the risk for the use of services.

SOURCE: Physician Payment Review Commission analysis based on Gold et al. 1995.

[7] See the introduction to Part II and Chapter 10 in the Commission's 1995 annual report for further discussion of this categorization of health plans (PPRC 1995).

businesses frequently self-insure, that is, retain at least some of the risk for health costs. Although self-insurance is most commonly discussed in the context of conventional insurance or PPOs, some companies are exploring self-insurance for HMOs where employees are locked into use of network providers. In 1995, 13 percent of firms of 200 or more workers fully or partially self-insured HMOs. This level is far lower than comparable levels for PPOs (82 percent) or POS plans (73 percent), but it may represent an important industry trend as firms seek new ways to help control costs (KPMG Peat Marwick 1995).

On a second dimension, the typology emphasizes the enrollee's perspective by considering whether he or she is locked into using network providers (or others by authorized referral) or is reimbursed in some way when using ones outside the network (Table 2-6). Historically, most HMOs required enrollees to use their provider network exclusively, while PPOs and fee-for-service plans permitted the use of nonnetwork providers. But this distinction has blurred recently as even some traditional group-model and staff-model HMOs have introduced point-of-service options.

Although HMOs that accept full risk and lock enrollees into plan providers have been the mainstay of managed care over the years, their growth has been generally flat over time (about one-fourth of workers in large firms) partly because of many people's reluctance to give up being reimbursed if they go outside the plan. In general, the greatest growth in health plan offerings has been in plans without a lock-in requirement. The biggest gains in the past few years have been in point-of-service plans, in which beneficiaries sign up with a network-based managed-care plan but retain the option to obtain services from out-of-network providers. A majority of HMOs now offer POS plans. According to data published by the Group Health Association of America, nearly 60 percent of HMOs offered a POS product in 1993, a substantial increase from 1990 when only 20 percent of plans offered such options (GHAA 1994). The use of these options by workers has also been growing dramatically. Enrollment among employees of medium to large firms (200 or more workers) grew from 3 percent in 1991 to 18 percent in 1995 (KPMG Peat Marwick 1995).

POTENTIAL PLAN OPTIONS IN AN EXPANDED MEDICARE

Recently there has been a great deal of interest in making a broader array of private plan options available to Medicare beneficiaries. As described earlier in the chapter, HCFA has expanded its POS option and is using demonstration authority to add other options. Its request for proposals under Medicare Choices solicited applications from plans seeking either full or partial-risk arrangements, with or without lock-ins to plan providers. The Administration's 1995 Medicare proposal took a similar approach, including options for both full and partial-risk contracts. The conference agreement passed by the Congress in November 1995 (H.R. 2491) would have expanded considerably the types of plans that could be offered, but would have required that all participating plans accept full risk for the cost of all services.

This section describes how current and proposed Medicare offerings fit into the four categories of the typology described above and where new options might be most likely (Table 2-7). The option in the conference agreement that combines a high-deductible insurance plan with a medical savings account, which does not fit easily into this typology, is discussed separately in Chapter 7. Issues relating specifically to plans offered by provider-sponsored organizations are discussed in Chapter 3.

Table 2-7. Managed-Care Options in Medicare

	Plan at Full Risk	Plan Not at Full Risk
Enrollees Locked In	Risk contracts with qualified HMOs or competitive medical plans. Enrollment is about 9 percent of beneficiaries.	No option currently available. Options may become available on a demonstration basis.
Enrollees Not Locked In	Risk contracts that include point-of-service options. Enrollment is minimal because this option is new in 1996.	Cost contracts, health care prepayment plans, and Medicare SELECT arrangements. Other arrangements may become available on a demonstration basis. Enrollment is about 3 percent of beneficiaries.

SOURCE: Physician Payment Review Commission analysis.

Plan at Full Risk, Enrollees Locked into Network Providers

As noted earlier, the risk contract is the most common managed-care offering in Medicare at present. In general, all HMOs that participate in private markets are eligible to participate in Medicare provided they are willing to enter into full-risk contracts. Certain Medicare policies, however, tend to restrict the numbers of plans that enter into risk contracts.

Although the number of participating plans has soared since 1991, even more plans might enter into risk contracts if changes are made in either Medicare's payment methodology or plan standards. For example, some plans claim that the requirement that no more than 50 percent of enrollees come from Medicare or Medicaid limits their ability to expand into new markets, especially those where the commercial market is already highly competitive. A description of the Commission's work and recommendations for changing how plans are paid is in Chapter 5, and a discussion of plan standards is in Chapter 3.

Plan at Full Risk, Enrollees Not Locked into Network Providers

About 4 in 10 managed-care enrollees in the private sector join a managed-care plan where they maintain an option to go out of network to obtain services. Before the recent issuance of Medicare POS guidelines and the forthcoming demonstrations under Medicare Choices, there were effectively no Medicare private plan options of this type.[8] As a result, this category may provide the most significant opportunities for new Medicare options.[9]

Options for full-risk plans without a lock-in to network providers could include PPOs that accept risk or point-of-service HMOs. The conference agreement would permit both types in Medicare, although it

[8] Although options did not exist for plans, beneficiaries in risk HMOs always had the option of going outside the plan's network by paying completely out of pocket.

[9] How much enrollment grows as a result of adding these options depends in part on how much they tempt those in traditional Medicare to try out a health plan versus attracting current risk-plan enrollees.

draws no explicit distinction between them and those plans that lock enrollees into network providers. Both PPOs and point-of-service HMOs have in common the flexibility of enrollee choice of provider, and both put the plan at risk for a premium or capitated payment. They differ in the involvement they have with their network providers. PPOs traditionally have looser arrangements with their physicians than do HMOs and are less likely to use profiling, practice guidelines, or quality monitoring with focused studies—although this may change as they accept full risk. By contrast, point-of-service HMOs use management tools extensively for in-network services, and they may seek to use them outside the network as much as possible (PPRC 1995; Gold et al. 1995).

The conference agreement also would permit private fee-for-service plans to participate in Medicare under full-risk contracts. It defines them as plans "that reimburse hospitals, physicians, and other providers on the basis of a privately determined fee schedule or other basis," and also refers to them as "unrestricted fee-for-service plans." Such a plan would operate similarly to a fee-for-service plan that contracts with large employers like the federal government. It would pay providers on a fee-for-service basis without any contractual relationships, but would agree to a per-person premium with Medicare, thereby putting itself at risk for its ability to keep costs within contracted levels.

The Administration proposal makes specific provision for participation by PPOs and further clarifies their classification in this category by requiring that PPOs include a point-of-service option; in other words, a PPO may not restrict enrollees to network providers. The Administration would also permit HMOs (although not provider-sponsored organizations) to offer a POS option as under current law.

Some beneficiary and provider groups support the idea of a mandatory POS option for all managed-care plans made available to Medicare beneficiaries.[10] They argue that access to nonnetwork providers offers beneficiaries a further guarantee of quality and allows excluded providers to treat patients in network-based plans. Although many health plans want more flexibility in offering POS options, they oppose a mandatory offering. They argue that it would limit their ability to coordinate care, oversee quality, and manage costs of services rendered to beneficiaries. In addition, plans in some states face regulatory obstacles in offering POS products.

Plan Not at Full Risk, Enrollees Locked into Network Providers

The next two categories raise the possibility of partial-risk contracts or new types of cost contracts for Medicare. Self-funding or self-insurance has been an important concept in the private sector, where some purchasers choose to retain some or all insurance risk for the services delivered to their workers. As noted above, large firms have been experimenting with self-funding their traditional HMOs. In addition, some employers have attempted to increase savings beyond what they can get from PPOs by eliminating employees' ability to go out of network for care. These arrangements, sometimes referred to as exclusive provider organizations, appear to be uncommon.

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[10] Maryland recently passed a law mandating that all HMOs offer a POS option. It allows but does not limit the size of additional premiums and higher copayments and deductibles for this option.

The conference agreement would not permit any plan to be at partial risk, but the Administration proposal would allow plans to contract on this basis. Partial-risk arrangements might prove attractive to provider-sponsored organizations seeking to offer Medicare plans, since they use such arrangements frequently in the private sector. Incorporating a lock-in to network providers, however, might make these arrangements less popular with beneficiaries or some providers.

Plan Not at Full Risk, Enrollees Not Locked into Network Providers

Current Medicare offerings in which plans are not at risk and enrollees are able to use any provider include cost contracts, health care prepayment plans, and Medicare SELECT arrangements. While they increase the choices available to beneficiaries, they are not available in all areas and have been chosen by only about 3 percent of all beneficiaries. By contrast, workers in large firms have many more options in this category (i.e., fully or partially self-funded PPOs or point-of-service plans) and choose them more often than they do those in any other category.

These three types of arrangements in Medicare, as currently constituted, leave all risk with the Medicare program. There is little evidence available on whether they generate savings for Medicare.[11] Any savings must result more from reduced utilization achieved through plan management or utilization review than from reductions in provider payments, as is more typically the case in the private sector.

It is possible that Medicare could contract with a wider variety of PPOs on a cost-contract or partial-risk basis. As noted above, the Medicare Choices demonstration may test some partial-risk arrangements, and the Administration proposal would authorize them on a permanent basis. Like large firms, Medicare might find that some PPOs are effective at negotiating directly with providers. To achieve savings, PPOs could negotiate fee discounts that would be shared with Medicare, or they could use Medicare's fees but reduce utilization through selecting efficient providers or imposing more intensive review.

Another approach advanced by some policymakers is the idea of a PPO maintained directly by Medicare. Under such an approach, providers who chose to be on Medicare's preferred provider list would provide fee discounts to Medicare.[12] Whether this approach is viable, given the discounts already embedded in the Medicare Fee Schedule, is an open question.

A further variant would have the Medicare program select network providers based on standards of quality and efficiency, with the goal of generating savings by reducing volume. But this type of Medicare PPO might run into opposition from those provider groups that have pushed for "any willing provider" laws to protect against arbitrary network selection decisions by plans. The stakes could be large if Medicare beneficiaries were given incentives to use the preferred providers. At the same time, choosing the most

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[11] No definitive evidence is available for cost-contract plans or HCPPs. Preliminary results from an evaluation of the Medicare SELECT program suggest a mixed picture on savings for Medicare.

[12] Medicare's system of participating physicians—who agree to accept the Medicare payment amount as full payment for all beneficiaries—could be characterized as a PPO. Because Medicare rates are already discounted, the program pays higher rates for participating physicians as an incentive for them to defer from balance billing beneficiaries.

cost-effective providers could have the potential for substantial savings because of reduced utilization. Medicare should have the ability to make reasoned selection decisions through its growing capacity to profile provider practice patterns (see Chapter 11).

MONITORING EFFECTS OF BROADENING HEALTH PLAN CHOICES

It will be important to monitor the implementation of any new system of Medicare private health plan options, whether it results from a major legislative restructuring of the program or from more incremental changes. Various changes are discussed in this report, including the expanded plan options described in this chapter and reforms in such areas as enrollment and disenrollment rules, payment methods, plan standards, and quality systems that are discussed in other chapters. The goal of a monitoring process is to assess how well these changes achieve their purpose and how they affect participating health plans, beneficiaries, and the Medicare program.

This section offers a general approach to monitoring. In developing this process, policymakers should consider appropriate measures to characterize the effects of policy changes, the length of time that the system is monitored, and ways to analyze both overall and local area trends.

A monitoring process should be designed to measure behavioral responses by health plans and beneficiaries that are expected to occur as more and different private health plan options become available. Particular attention should be given to policy issues that are of greatest concern or uncertainty, including:

- the availability, both nationally and in specific markets, of different types of plans and the decisions by beneficiaries whether to enroll in them;
- changes in enrollment that might result from restructured enrollment rules and marketing standards;
- the effects of disenrollment policy on risk selection or access to quality care;
- changes in total costs to beneficiaries under new plan arrangements; and
- the effects of changes in standards for quality and solvency on the outcomes of care.

Measures to evaluate these and other issues should be selected to reflect as closely as possible the expected responses to policy changes. They also should be quantifiable, and the information required to assess each one should be routinely available or feasible to collect on a periodic basis. Monitoring should be conducted for several years following implementation of any policy changes. Such an approach recognizes that policy changes may stimulate both immediate and delayed responses by plans and beneficiaries.

Because the response generally would be taking place in local markets, a monitoring strategy should include examination of both overall national trends and patterns of change in specific markets. Markets

selected for monitoring should be those that were expected to experience the largest effects of policy changes or that represented other important policy issues for a restructured Medicare program. They should also represent different regions of the country and cover both high-penetration and low-penetration markets.

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Standards for Plan Participation in Medicare

Broadening private health plan participation in Medicare presents both an opportunity and the necessity of reviewing existing standards for health plans. Medicare restructuring could accelerate the development and diffusion of new standards, building on efforts in the private sector where appropriate. Although new legislation would present opportunities to improve existing standards, Medicare will continue to be responsible for protecting beneficiaries from unfair marketing practices, maintaining a high level of quality and access to care, and securing the fiscal integrity of health plans. These issues will be especially important if Medicare allows new and untested forms of health plans to compete to serve beneficiaries.

In examining these issues, the Commission has endorsed the general principle that all private health plans participating in Medicare should meet the same core standards. Some of the standards found in most legislative proposals include the need to offer all Medicare-covered benefits, guarantee a minimum level of access to these benefits, maintain a quality assurance program, disclose certain information to beneficiaries, protect beneficiaries against plan insolvency, and limit high out-of-pocket costs.

In addition to focusing on the general role of plan standards in a restructured Medicare, this chapter looks at several standards in more detail, including those dealing with plan insolvency and beneficiary financial liability. Other standards, such as quality assurance and appeals rights, are discussed in other chapters. In these discussions, the Commission considers the complexities policymakers face as they move from broad principles to specific rules.

This chapter includes:

- *Plan standards*
- *Applicability of standards to provider-sponsored organizations*
- *Protecting beneficiaries from plan insolvency*
- *Beneficiary financial liability*

The Commission has made several detailed recommendations to implement one broad principle: limiting the financial liability that may be incurred by beneficiaries for physicians' services. Traditional Medicare guarantees that beneficiaries' liability for physicians' services, in addition to the standard deductible and coinsurance amounts, may not exceed 15 percent of the Medicare payment amount. This policy was endorsed by the Commission in 1989 as part of its recommendations for physician payment reform. This year, the Commission has modified this policy with respect to beneficiaries enrolling in private health plan options, looking separately at different circumstances such as use of in-network versus out-of-network services.

Recommendations

The same core standards should be applied to all private health plans participating in Medicare. Flexibility should be used in developing and enforcing standards and rules as appropriate given differences in plan design.

Under a private health plan participating in Medicare, a beneficiary's financial liability for services delivered by network providers having a contractual relationship with the plan should not exceed (after taking into account any deductible and copayment) the liability the beneficiary would have had with participating providers under traditional Medicare. For emergency services and authorized referrals by the plan to nonnetwork providers, the same limits on a beneficiary's liability should apply as would for services delivered by network providers.

Informational materials provided to Medicare beneficiaries during any open enrollment season should describe the potential out-of-pocket liability (including any possibility of balance bills) that could be incurred by enrollees in all private health plans, as well as under traditional Medicare.

Current responsibility assigned to both the Secretary of Health and Human Services and the Commission for monitoring beneficiary financial liability in traditional Medicare should be extended to beneficiaries enrolled in private health plans participating in Medicare. Approaches to collecting data should be developed to support this activity.

As a result of these recommendations on beneficiary financial liability, beneficiaries would not be protected from additional bills above the plan's payment when they choose to use nonnetwork providers other than in emergencies or by authorized referral. These circumstances include all services delivered in private fee-for-service health plans, in fee-for-service plans combined with medical savings accounts (MSAs), or by nonnetwork providers under point-of-service (POS) options.

This chapter describes current Medicare standards for participating private health plans and then examines baseline standards that might be appropriate if Medicare broadens options for plan participation. It gives

particular attention to the applicability of standards to different types of health plans, including provider-sponsored organizations (PSOs). The chapter includes sections on plan solvency requirements and rules that require a minimum percentage of commercial enrollment and a minimum overall level of enrollment. Finally, policies concerning beneficiary financial liability for physicians' services are discussed in greater depth.

STANDARDS IN CURRENT MEDICARE LAW

The framework and specific requirements for health plan participation in the current Medicare program have been established at the federal level (Section 1876 of the Social Security Act). Federal law or regulations include requirements for plans in the areas of quality assurance, access to care, enrollment and disenrollment, benefits, marketing, and financial solvency. They also establish protections for those Medicare beneficiaries enrolled in managed-care plans, including quality of care assessments by peer review organizations, grievance and appeals processes at the plan level and above, and arrangements for beneficiaries whose plan relinquishes or loses its Medicare contract. The Secretary of Health and Human Services is responsible for interpreting these requirements, promulgating regulations, and monitoring compliance. The Secretary is authorized to impose financial penalties, suspend enrollment, stop payment, or terminate contracts for plans that violate the conditions of their contracts or fail to meet qualifications for participation.

States also play a key role in plan standards, as Medicare requires that plans be licensed under applicable state law. By law and tradition, states have jurisdiction over insurers and health plans. Health maintenance organizations (HMOs) and some point-of-service plans typically fall under the jurisdiction of state HMO laws, whereas preferred provider organizations (PPOs), fee-for-service plans, and some POS plans fall under insurance law (or state PPO acts where they exist). As described later in the chapter, the applicability of these various laws to newer forms of managed care has been a point of controversy.

The Health Care Financing Administration (HCFA) monitors compliance with Medicare managed-care plan program requirements through reviews of plans' documents as well as site visits to the plans. When applying for a Medicare risk contract, plans must document their qualifications for participating in Medicare. In addition, they are required to submit annual reports documenting their financial solvency. Throughout the year, plans submit updates on enrollment and disenrollment. Plans are also expected to collect and submit detailed information about hospital inpatient stays (i.e., no-pay bills), although in practice only a fraction of plans do so.

HCFA previously conducted site visits to each Medicare managed-care plan every two years, but is starting to conduct them annually beginning in 1996. A site visit review includes inspection of data on a plan's enrollment (including denials), disenrollment, financial performance, quality assurance, provider contracts, and grievances and appeals. These data are not directly collected by HCFA, but are supplied by the plan. An unsatisfactory review can result in termination of a plan's contract or lesser penalties such as suspension of new enrollment.

PLAN STANDARDS UNDER A RESTRUCTURED MEDICARE

Several major decisions must be made in the development of health plan standards for a restructured Medicare program. This section discusses decisions about the content of standards and the types of plans to which they would be applied. It does not address the roles of different groups or levels of government in developing, monitoring, and enforcing these standards.

The Commission has concluded that the same core standards should apply to all private health plans participating in Medicare. All plans, for example, should be required to have adequate resources and reserves to ensure that beneficiaries are protected in case of insolvency or similar problems. At the same time, the Commission acknowledges that the implementation and enforcement of specific standards and the rules used to enforce them will require flexibility, given differences in plan design. It may be appropriate, for instance, to apply solvency standards differently to plans at full risk than to those with partial-risk contracts. It may also be reasonable to apply solvency standards differently to plans owned by providers of care than to those that contract with providers.

The Content of Plan Standards

A variety of purchasers—Medicare, Medicaid, and private employers among them—have found it prudent to develop standards for health plans. These standards are expected to ensure consumer protection, establish fair market rules for competition, and limit the potential for fraud and abuse.

Restructuring the Medicare program may decrease the need for standards in some areas and increase it in others. For example, adoption of state-of-the-art quality assurance standards could permit the Medicare program to drop the rule that limits Medicare and Medicaid enrollment to half of total plan enrollment. Additionally, greater ability to monitor outcomes could reduce reliance on process requirements for quality assurance programs (see Chapter 6). At the same time, the involvement of new and untested forms of managed care in Medicare highlights the need for adequate standards to avoid fraud and abuse like that which accompanied the rapid development of Medicaid managed care in California during the 1970s or Florida in the 1990s.

Most Medicare proposals considered by the Congress in 1995 provide general areas in which standards for Medicare plans are to be developed, but do not enumerate specific requirements in the legislation. Under the provisions of the conference agreement passed by the Congress in November 1995 (H.R. 2491), for example, health plans would have to meet certain broad requirements to participate in MedicarePlus, the proposed program encompassing all private health plan options for Medicare.[1] As stipulated in the conference agreement, participating plans would have to:

- provide all Medicare-covered benefits to enrolled members,

[1] Some exceptions are made to these requirements for private fee-for-service plans, plans affiliated with medical savings accounts, and plans offered by provider-sponsored organizations. These are discussed later in the chapter.

- guarantee a minimum level of access to services,
- maintain a quality assurance program,
- protect beneficiaries from high out-of-pocket costs,
- meet conditions to guarantee financial solvency and protect beneficiaries in case of insolvency,
- be organized and licensed under state law as a risk-bearing entity,
- assume full financial risk for the provision of health services, and
- meet minimum enrollment requirements after the first three years of operation.

This chapter includes a consideration of how these broad standards might be applied to different types of health plans, as well as discussions of specific standards on solvency, minimum enrollment, and beneficiary financial liability. Quality standards and grievance and appeals processes are examined in Chapters 6 and 8.

Scope of Application for Plan Standards

A broader range of types of private health plans would be permitted to enroll Medicare beneficiaries under most restructuring proposals (see Chapter 2). In addition to HMOs, which traditionally have held Medicare risk contracts, options might include plans that reimburse beneficiaries for use of nonnetwork providers (HMOs with a point-of-service option or PPOs), private fee-for-service plans that have no network of contracted providers, plans that combine high-deductible insurance with a medical savings account, and plans offered by provider-sponsored organizations.[2] This broadening of the program requires decisions about whether the same standards should apply to all types of plans or whether distinct standards should be applied to different categories of health plans.

State activities help to inform these decisions for two reasons. First, the Medicare requirement that plans be licensed under state law (although exceptions might be granted) means that the federal government will partially pass this issue on to the states. Second, lessons may be learned from those states that have dealt recently with the issue as they sought to update state licensure laws.

As noted previously, nearly all states have enacted licensure laws that apply certain standards to HMOs. Although the plan standards used by Medicare or by many private purchasers are more comprehensive

[2] A PSO is defined in the conference agreement as a public or private entity that meets three criteria: (1) it is established or organized by a health care provider or group of affiliated health care providers, (2) it provides a substantial proportion of Medicare-covered items and services directly through the provider or affiliated group of providers, and (3) those affiliated providers that share substantial financial risk for the provision of these items and services have at least a majority financial interest in the entity.

than many state licensure laws, the state standards provide a baseline starting point. About half of current state HMO acts are based on a model act originally adopted by the National Association of Insurance Commissioners (NAIC) in 1972. It includes fairly specific requirements in areas such as solvency, quality assurance, and grievance procedures (NAIC 1990).

In its model act, NAIC defines an HMO as an entity that "undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments and/or deductibles" (NAIC 1990). The scope of this definition is broad enough that it could potentially encompass all risk-bearing entities providing health care services, whether or not they label themselves HMOs. Attempts to apply these laws beyond HMOs, however, have been met with objections.

In addition to their HMO acts, about 27 states have enacted PPO acts, which are generally less comprehensive. Basically, NAIC's model PPO act allows PPOs to establish terms of payment for the providers with which they contract and to include mechanisms to contain costs. In contrast to the HMO model act, it is not intended to regulate risk-bearing entities and thus includes no requirements in areas such as solvency, quality assurance, or grievances (NAIC 1987).

An emerging issue in many states is the legal status of entities that do not consider themselves HMOs, especially provider-sponsored integrated systems such as physician hospital organizations (PHOs) and other types of PSOs. A recent survey of state regulators by the Group Health Association of America found that most states expected these entities to get HMO licenses if they accept full risk. If they assumed no risk, most states agreed that no licensing was necessary. But the picture was quite mixed if the arrangements involved partial risk or downstream risk, the latter meaning that the entity accepts risk from (e.g., is capitated by) a licensed organization like an HMO. For each of these circumstances, about half the states had no clear policy (GHAA 1995).

The states are attempting to clarify the situation. Iowa and Minnesota have rewritten their insurance laws to address provider-sponsored integrated systems.[3] In 1995, the NAIC issued a draft bulletin to the states stating that unlicensed integrated delivery systems or PHOs should be permitted to accept only downstream risk from an HMO or similar entity without being licensed themselves. Additionally, NAIC has been reviewing its model laws to increase the use of common definitions and regulation of entities with similar characteristics. It expects to incorporate new standards for quality and solvency as part of this project.

Both the Administration proposal and the conference agreement anticipate some need for separate treatment for PSOs. For example, the conference agreement would give plans offered by PSOs special rules with respect to certain requirements that otherwise apply to all participating health plans, including state licensure requirements, solvency standards, and minimum enrollment requirements.

The availability of waivers of state licensure requirements responds to the concern of PSOs and those who might create them that state licensure agencies may impose long delays in reviewing applications or may

[3] See Chapter 11 of the *Annual Report to Congress 1995* (PPRC 1995a).

fail to acknowledge legitimate differences between PSOs and traditional insurers or health plans. The conference agreement provides all plans with an opportunity for a waiver of state licensure requirements in the case of delays or the imposition of unreasonable barriers to market entry.[4] It provides additional circumstances under which PSOs could request a waiver, specifically, if the state imposes requirements or standards "not generally applicable to any other entities engaged in substantially similar business." Special solvency standards and enrollment requirements for PSOs are discussed further below.

Private fee-for-service plans would be permitted to participate in Medicare on a full-risk basis under the conference agreement, but could not participate at all under the Administration proposal. The conference agreement, which sometimes refers to these plans as "unrestricted fee-for-service plans," exempts them from the following requirements that otherwise apply to all plans:

- limits on beneficiary financial liability, including for emergency services;
- quality assurance programs, including external review; and
- rules regarding physician participation in networks, which by definition do not exist for these plans.

In part, the exclusion from quality standards reflects the inapplicability of certain rules when no contractual relationship exists between the plan and individual providers. But the total exclusion from any type of external utilization review also reflects a policy decision that some beneficiaries oppose any intervention (whether imposed by a private plan or a peer review organization) that might disallow or oversee in any way (ration, in the view of these beneficiaries) desired medical services.[5]

STANDARDS FOR PROTECTING BENEFICIARIES FROM PLAN INSOLVENCY

Under current law, a Medicare risk contractor must provide evidence to the Secretary that it has made adequate provision against the risk of insolvency. Measures may take the form of reserve requirements or other means of ensuring that services delivered to beneficiaries will be paid. Both the conference agreement and the Administration proposal include solvency standards. The language in the conference agreement specifically states that each MedicarePlus organization must meet standards relating to financial solvency and capital adequacy and must include a provision "to prevent enrollees from being held liable to any person or entity for the plan sponsor's debts in the event of the plan sponsor's insolvency."

The Commission's recommendation of flexibility in implementation and enforcement seems appropriate for solvency standards. The specific rules that apply to organizations with partial-risk contracts and to

[4] This waiver, if broadly interpreted, could dramatically reduce the role of state licensure; regulations could be designed to limit its scope.

[5] A more detailed discussion of appropriate exclusions from quality requirements is in Chapter 6.

provider-sponsored organizations with any type of contract may need to differ from those that apply to HMOs at full risk.[6]

It is appropriate that plans with full-risk contracts meet tougher solvency standards than those with partial-risk contracts, because the purchaser (Medicare) is sharing financial risk with the plan in the latter case. Most state HMO laws apply strict solvency standards to plans with full-risk contracts, whereas PPO laws assume that the purchaser retains most or all of the risk and thus typically have no solvency standards. Although the conference agreement does not permit partial-risk contracts, the Administration proposal would do so and includes language allowing the Secretary to set solvency standards appropriate to these contracts.

A second issue is the appropriate treatment of provider-sponsored organizations. As described above, the NAIC has recommended that provider-sponsored organizations without HMO licenses should only be permitted to accept downstream risk from a licensed entity such as an HMO—placing the legal responsibility with the HMO. Recently, a Pittsburgh HMO with a Medicare risk contract became one of the first to transfer risk fully to a provider organization (Roberts 1996). Such arrangements are common in the private sector, where PSOs often contract with HMOs in a way that puts them at least partially at risk for the services they deliver. PSOs also may contract directly with self-insured employers, again under partial-risk arrangements. In cases where PSOs have preferred to enter into full-risk arrangements, they must usually comply with state HMO standards.

Provider organizations are concerned that states' unfamiliarity with PSOs may create difficulties or at least impose significant delays if PSOs are required to get HMO licenses. They contend that PSOs look different from traditional insurers because they are in the business of providing most health care services, not buying them.[7] PSOs might appropriately count some of their delivery system assets—in addition to cash reserves—in meeting solvency standards. Moreover, a PSO can credibly promise through its provider contracts not to make beneficiaries liable for the cost of services furnished by the PSO—no matter what happens to the financial bottom line. The NAIC is developing new standards designed to take the relative liquidity of plan assets into account for purposes of reserves and solvency requirements, and a few states have taken steps to modify existing standards or establish separate licensing legislation for provider-based plans.

Both the conference agreement and the Administration proposal anticipate applying standards differently to PSOs than to other plans. The Administration proposal would require the Secretary to develop separate solvency standards for PSOs. The conference agreement also assigns responsibility for developing and enforcing solvency standards for PSOs to the federal government—even though it generally assigns enforcement responsibilities for other plans to the states. This decision apparently responds to the concern of PSOs that state agencies may not treat them promptly or fairly.

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[6] The roles of full-risk and partial-risk contracts in Medicare are discussed in Chapter 2.

[7] In this sense, PSOs may not be different from some group-model or staff-model HMOs, especially those that own hospitals.

The two proposals also differ in that the conference agreement would require PSOs that participate in Medicare to enter into full-risk contracts, whereas the Administration would allow partial-risk contracts. The rule in the conference agreement would put them at risk for all services included in the Medicare benefit package, including many (e.g., durable medical equipment or home health services) for which subcontracting arrangements may be necessary.

Because PSOs that seek to enroll beneficiaries at full risk may be staking out new territory, it might be appropriate to ask them to meet solvency standards at least as stringent as those that other plans meet—rather than offer them exemptions from standard requirements. Alternatively, PSOs could be encouraged to contract on a partial-risk basis.

The principal question should be whether applying separate standards creates inappropriate risks for beneficiaries. Are physicians more likely to continue providing services if the PSO with which they contract or in which they have invested runs out of money than if the insurer or health plan to which they send bills becomes insolvent? In either case, they will find themselves equally uncompensated. Will a hospital that is at the core of a PHO continue to provide care when money runs out, or will it simply close its doors for good?

From Medicare's perspective, the ultimate issue should be whether beneficiaries are provided a reasonable guarantee of continued services without added financial liability in the event of insolvency. Whereas this protection has traditionally taken the form of cash reserves, it could also be a contractual requirement for physician-owners or physician-investors to continue caring for patients without compensation, until enrollees have an opportunity to join another plan. Reserves may still be necessary to guarantee payment to providers without an equity stake or to an alternative hospital if the participating one goes out of business. But these reserves might appropriately be smaller than for a plan where no provider has an equity stake.

CONTINUED ROLE OF STANDARDS FOR MINIMUM ENROLLMENT

Medicare law contains two rules concerning levels of enrollment in risk-contracting plans. These rules are said to have been established as proxies to ensure a plan's quality of care and also to help ensure that the adjusted community rate, which is based on private premiums, can be calculated.[8] The rules may also serve as proxies for an organization's stability or track record.

One rule requires that plans cover at least 5,000 members (1,500 in rural areas). The other, known as the 50/50 rule, requires that Medicare and Medicaid enrollees in total may not exceed 50 percent of plan enrollment. Exceptions may be granted for plans that serve areas in which the combined Medicare and Medicaid population exceeds 50 percent or for plans that are determined to be making reasonable efforts to enroll commercial members.

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[8] The adjusted community rate is used to enforce Medicare's requirement that a plan must return any surplus revenue to Medicare or spend it by providing supplemental benefits to Medicare enrollees (see Chapter 5).

Many policymakers have called either for elimination of the 50/50 rule or for greater flexibility. The conference agreement would repeal the 50/50 rule and would reduce the minimum enrollment requirement for PSOs. The Administration bill would retain the 50/50 rule but allows for new waivers, for example, if a plan has experience with Medicare in three other areas in the country. It also sets conditions for dropping the rule in the future once a quality measurement system is in place.

Other policymakers are concerned about the Medicare participation of start-up plans or those with little established track record. One recent suggestion was that a plan be permitted to participate in Medicare only if it had been in existence for at least three years to demonstrate financial and operational competence. In addition, it would need to document that its executives and marketing personnel had no prior convictions for violating state insurance or HMO laws. Such an approach represents one way to balance goals of protecting beneficiaries from fraudulent plan operators and encouraging new plans to enter the market.

STANDARDS FOR BENEFICIARY FINANCIAL LIABILITY FOR PHYSICIANS' SERVICES

As beneficiaries are given a wider range of coverage options, they may face new decisions concerning the amount of financial risk that they are willing to accept in exchange for other features of health plans. In order to make such decisions appropriately, beneficiaries would need to be fully informed of their potential financial liability as well as other attributes of the plans. With the many subtleties involved in coverage policies and cost-sharing responsibilities of different types of plans, adequately informing beneficiaries of the trade-offs involved might prove to be a challenge.

The Commission has long been interested in the impact of physician payment policy on the financial liability of Medicare beneficiaries.[9] In response to past concerns about the effect of rising program costs on beneficiaries, Medicare fee-for-service payment policy employs a series of mechanisms that limit provider charges in order to shield beneficiaries from high out-of-pocket expenses at the point of seeking care. Similarly, beneficiaries choosing to enroll in Medicare risk-contracting plans are protected by different policies that typically limit cost sharing.

If Medicare beneficiaries are offered additional options as a result of new legislation, questions arise whether comparable protections for beneficiaries will be maintained. Additional issues include the extent to which new options would affect beneficiaries' out-of-pocket costs, the capability of beneficiaries participating in the system to understand their cost-sharing obligations, and the necessity for financial liability to be monitored. Compared with the current Medicare program, private insurance options may decrease out-of-pocket expenses for some beneficiaries, while possibly increasing them for others. The overall outcome would depend upon the types of plans beneficiaries select and the extent to which those enrolled in plans with contractual networks of providers make use of those providers, rather than seeking care outside the network.

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[9] This chapter focuses on protecting beneficiaries from financial liability for physicians' services. It does not address the implementation of similar rules for other services, which could be difficult and could come with high financial consequences.

Beneficiary Financial Liability in Traditional Medicare

Medicare fee-for-service physician payment policies have effectively limited the cost sharing borne by beneficiaries. One important factor contributing to this outcome has been the option for providers to bill on assignment, whereby they accept the Medicare payment as full compensation and receive most of the payment directly from Medicare. For physicians' services, beneficiaries are individually responsible for an annual $100 deductible, coinsurance of 20 percent of the Medicare payment, and bills of up to 15 percent of the Medicare payment amount on unassigned claims (known as balance bills).

The Participating Physician and Supplier (PAR) program has played a large role in encouraging physicians to accept all claims on assignment. Like physicians participating in private insurer networks, PAR physicians agree to accept the Medicare-allowed charge as payment in full on all claims, forgoing the opportunity to bill patients any additional amount. In return, these physicians are paid roughly 5 percent more than non-PAR physicians (non-PAR physicians are paid 95 percent of the fee schedule amount), are listed in a published directory made available to beneficiaries, and receive expedited claims processing. The proportion of providers choosing to participate has increased steadily each year from about 30 percent of providers billing Medicare in 1984 to 72 percent in 1995 (PPRC 1995b). Further, the proportion of charges for services submitted on assignment by all physicians has soared over the past several years, reaching 95 percent in 1995 (see Chapter 12).

For those charges that are not submitted on assignment, the Omnibus Budget Reconciliation Act of 1989 (OBRA89) specifies percentage limits on the amount that a physician can bill beneficiaries. Current policy directs that a physician may not charge more than 115 percent of the payment under the Medicare Fee Schedule (which differs based on being a PAR or non-PAR physician) for a given service. Consequently, the size of balance bills has declined substantially in keeping with this law (PPRC 1995b).

Beneficiary Financial Liability under Medicare Risk Contracts

Beneficiaries enrolled in health plans with Medicare risk contracts generally are not responsible for large out-of-pocket charges for physicians' services. Because these plans must assume full financial risk for the provision of health services, most care is furnished by providers with whom the organization has contractual agreements. Beneficiary cost-sharing requirements may take the form of copayments, coinsurance, or deductibles—the total of which may not exceed those that would be allowed on average under the fee-for-service Medicare program.[10] While there is no explicit legislative language prohibiting plans' network providers from balance billing enrollees for additional charges, Medicare contracting agreements do not allow this practice.

In cases in which risk-contracting plans authorize referrals to providers who do not contract with the plan, current Medicare law specifies that beneficiaries' liability for physicians' services is limited to that allowed under the fee-for-service system. Specifically, beneficiaries may be accountable at most for a

[10] Plans may also substitute a higher premium for lower cost-sharing requirements. This determination is made in connection with the requirement that a plan return any surplus revenue to Medicare or spend it by providing supplemental benefits.

coinsurance percentage calculated based on the Medicare Fee Schedule payment amount, and balance billing of up to 15 percent of the fee schedule amount for services provided by non-PAR providers.

Under HCFA's recent guidelines for the Medicare point-of-service option, risk plans have the flexibility to set premiums, coinsurance, copayments, and deductibles (see Chapter 2). But nonnetwork providers seen on a point-of-service basis are bound by Medicare Fee Schedule payment policies and balance billing limits, just as they are when seen on an authorized referral. To ensure that enrollees are not incorrectly charged, the guidelines require plans to pay providers directly for these services.

Beneficiary Financial Liability under Expanded Medicare Options

The diverse cost-sharing requirements associated with private-sector coverage options would raise a variety of issues and concerns if applied to the Medicare population. Beneficiaries choosing to enroll in private health plans under Medicare would likely encounter policies that diverge from those established in the traditional Medicare program. For example, under managed-care options such as PPOs or point-of-service plans, cost-sharing requirements frequently differ depending on whether the provider has a contractual relationship with the plan. Additionally, in cases where plans do not have contractual relationships with providers, plans may differ in their rate of payment to providers.

The lack of uniform payment rates raises issues such as the extent to which beneficiaries are responsible for charges that exceed the plans' payment amount (balance bills), as well as possible inconsistencies in the amount charged by providers and the amount that actually accrues toward the deductible. Private-sector plan members are generally responsible for all charges by nonnetwork providers beyond what is paid by the plan.

Medicare restructuring proposals have responded differently to the issue of whether and how to protect beneficiaries who select private health plan options from potentially large balance bills. A general rule in current law and in both proposals is that, on average, total beneficiary cost sharing (including any deductible, coinsurance, and copayments) cannot exceed that in traditional Medicare, even though cost sharing may be structured differently. The proposals diverge, however, when considering liability for balance bills.

Under the Administration proposal, balance billing would be restricted in all situations. Network providers, who have contractual agreements with the plan, would not be permitted to balance bill and would be required to accept the Medicare Fee Schedule amount as payment in full. Nonnetwork providers would also be required to accept the Medicare Fee Schedule amount; their ability to balance bill would be limited by the same restrictions that exist under traditional Medicare. The result for beneficiaries would be the certainty that balance billing liability under private plan options could not exceed that in traditional Medicare. The Administration proposal appears not to address whether plans could require beneficiaries to pay a higher coinsurance rate when using nonnetwork providers under a POS option.

Under the conference agreement, beneficiaries who choose to enroll in MedicarePlus plans would be protected from balance billing by network providers. Specifically, the legislation states that the

beneficiary's liability cannot exceed the lower of (1) what it would have been for a participating physician under traditional Medicare or (2) the traditional Medicare coinsurance (normally, 20 percent) applied to any lower fee paid by the plan.

The conference agreement would also protect beneficiaries from unlimited balance billing for emergency services, regardless of whether providers have contractual arrangements with the plan. In this case, the beneficiary's liability for balance bills would be limited under the rules for traditional Medicare. Correspondingly, these providers would be allowed to charge no more than that permitted under traditional Medicare, based on whether they have participation agreements or not.

Under the conference agreement, however, beneficiaries would not be guaranteed balance billing protection in the following circumstances:

- services delivered by providers who do not have contractual agreements with the plan, whether the decision to use nonnetwork providers is made by the plan or by the beneficiary; and

- any services provided to beneficiaries enrolled in private fee-for-service MedicarePlus plans or high-deductible plans with medical savings accounts.

The Commission's recommendation takes a position that falls between the sets of rules in these two legislative proposals. It incorporates full protection from balance billing for services delivered by network providers and for emergency services. The Commission's recommendation further extends the same protection when the plan makes a authorized referral to a nonnetwork provider. It would thus ensure, as does current law for risk contracts, that a decision by the plan to refer beneficiaries out of network does not leave them with financial liability over which they have no control.[11]

The Commission's recommendation, like the conference agreement, leaves providers with no restrictions on the balance bills they may charge to beneficiaries who choose to exercise a point-of-service option or who select private fee-for-service plans or high-deductible plans with MSAs. These are all options where beneficiaries would be given the opportunity to choose—either when they select a plan or when they select a nonnetwork provider—to expose themselves to potentially higher out-of-pocket costs in exchange for other plan features.

The absence of balance billing limits for services delivered in private fee-for-service plans and plans associated with MSAs could leave beneficiaries exposed to substantial out-of-pocket liability. Under proposed legislation, these plans would be free to pay physicians on the basis of any fee schedule as long as it is not lower than Medicare's. Thus, for example, if a plan uses Medicare's payment rates and physicians charge at the level typically paid by private payers, balance bills would be in the range of 40 percent of the bill—based on Medicare paying 71 percent of typical private payer fees (see Chapter 12). This amount would be in addition to the 20 percent coinsurance requirement.

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[11] The Commission's recommendation assumes that if plans set a deductible, it should not exceed the comparable deductible under traditional Medicare.

In the case of beneficiaries who use MSAs with high-deductible plans, additional issues arise. Although enrollees could draw from their MSAs to pay the entire bill, amounts above the plan's fee schedule would not have to be credited toward the deductible. Furthermore, enrollees would probably continue to be liable for potentially large balance bills after meeting the deductible. In other words, total out-of-pocket liability would most likely not be limited to the deductible amount (see Chapter 7).

Private fee-for-service and MSA plans could choose to pay providers at a higher rate than Medicare pays; in doing so, they would build more of their enrollees' liability into the plan premium. Alternatively, these plans could choose to cover all extra billing charges, that is, to pay the full bill submitted by the physician (leaving the beneficiary liable only for coinsurance). Because these plans would have no arrangements with physicians, however, they could not limit what physicians could charge. As a result, the latter option would be both costly and unrealistic.

Beneficiary Understanding of Financial Liability Requirements

To promote informed decisionmaking by beneficiaries, particularly when financial liability is unrestricted, the Commission recommends that plans make full disclosure of the potential out-of-pocket liability beneficiaries may face under different circumstances. Information describing cost-sharing policies will be important for beneficiaries in selecting a plan, as well as for understanding reimbursement policies once enrolled in a plan. The legislative language included in the conference report does not include potential liability for cost sharing for out-of-network services in its disclosure requirements, although it was in the earlier House-passed version of the legislation.

Disclosure should take place in two forms. First, plan comparison booklets distributed by the Secretary to all beneficiaries should have complete information on out-of-pocket liability, including the possibility of balance bills, for all plans and for traditional Medicare. To the extent possible, plans should report actual average out-of-pocket costs for their beneficiaries. This information should permit beneficiaries to compare options on this criterion before opting for a particular plan (see Chapter 4). Second, plans would be expected to disclose current information to their enrollees each year as part of a general notice of rights and responsibilities. This disclosure might give more detailed information on how bills for out-of-network services would be submitted and paid and where liability might occur.

Even with these disclosure requirements, beneficiaries might face difficulties in understanding reimbursement policies once enrolled in a plan, just as they do in the current Medicare program. Consequently, determining how much they are obliged to pay for services may be a challenge, especially when providers send bills directly to the patient. Under the current Medicare fee-for-service system, where providers are prohibited from billing beneficiaries above the limiting charge, Medicare carriers advise physicians of excess charges and of their responsibility to refund surplus receipts. Further, beneficiaries receive an Explanation of Medicare Benefits (EOMB) form indicating the limiting charge for services received.

In general, legislative proposals do not specify how various billing limits under private plan options would be enforced or the role of plans in doing so. For example, beneficiaries enrolled in plans with provider

networks who require emergency services might not be aware that they need not pay balance bills above Medicare's limiting charge. Additionally, beneficiaries referred for services from nonnetwork providers may face difficulty determining their required payments in the absence of an equivalent to the EOMB form. These concerns could be addressed individually by the plans or in regulations applying to all plans.

Monitoring Beneficiary Financial Liability under Expanded Medicare Options

With an expanded array of options and corresponding cost-sharing requirements, monitoring beneficiaries' exposure to high out-of-pocket costs becomes increasingly important. For the traditional Medicare fee-for-service program, both the Commission and the Secretary of Health and Human Services are required to report annually on beneficiaries' financial liability. The conference agreement, however, includes no parallel provision for participants in private health plan options beyond a general mandate for the Commission to report on the impact of the MedicarePlus program on access to care. If providers are permitted to bill beneficiaries directly for any charges that exceed a plan's payments (as would be the case under the conference agreement for plans that permit use of nonnetwork providers), no mechanism would exist to track the amounts actually charged by providers or the amounts actually paid by beneficiaries.

The Commission is recommending that current monitoring responsibilities be extended to include beneficiaries enrolled in private plans participating in Medicare. Assuming that cost sharing for in-network services would be limited, monitoring payments required from nonnetwork providers would be most important. Because coinsurance and deductible obligations will undoubtedly differ across plans, this process is likely to be somewhat complicated. To monitor beneficiary liability most effectively, it would be ideal to collect information on providers' charges, plans' payments, and beneficiaries' payments for a given service. Collecting a complete set of such information, however, may be difficult.

Several approaches to collecting these data might be considered, although complications are associated with each one. One option, which would also simplify beneficiaries' payment responsibilities, would be to require providers to submit all bills to the plans. This approach is recommended by HCFA in its guidelines for risk contractors offering a Medicare POS option. Plans could determine their payment responsibility and send a notice to beneficiaries indicating how much they owe the provider. Plans would then have the data to report on how much beneficiaries were charged (but not whether these amounts were actually collected). Although this approach would simplify the process for beneficiaries, it could prove to be a significant administrative burden for plans, especially those not accustomed to handling individual claims.

Another option would be available if use of centralized electronic claims processing clearinghouses becomes more widespread.[12] The clearinghouse would receive the bill from the provider and divide payment responsibility, based on the plan's rules, between the plan and the enrollee. The clearinghouse could then provide the data needed for monitoring. If data on charges and payments cannot be obtained in these ways, a less intrusive but less effective option would be to survey beneficiaries about the bills they pay out of pocket. This approach has the disadvantage of relying on beneficiaries' recollections of the bills

[12] See Chapter 16 of the *Annual Report to Congress 1994* for the Commission's recommendation on regional data clearinghouses that collect all claims data and utilization data directly from providers, plans, and consumers (PPRC 1994).

they received and the amounts paid. To reduce the costs that such a survey might impose on the Medicare program, it could be combined with surveys to monitor access to care.

Assuming a suitable mechanism can be put in place, tracking beneficiary financial liability can play an important part in the overall monitoring process described in Chapter 2. The question whether out-of-pocket costs rise under new Medicare options may be one factor policymakers may want to consider in evaluating the success of Medicare restructuring.

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Chapter 4

Facilitating Beneficiary Choice

Medicare beneficiaries will likely face significant changes in the availability of private health plan options, whether or not Medicare reforms become law. The choices available today are limited, but they have been expanding in many parts of the country. Proposed policy initiatives could broaden the offerings substantially. Beneficiaries' ability to make intelligent choices among a broader set of options will be facilitated by at least three conditions: an enrollment process that encourages comparisons among options, readily available information from neutral sources, and protections against marketing approaches that do not honestly represent the available choices.

These conditions are not well met in the current Medicare program, which generally requires beneficiaries to familiarize themselves with their options in a relatively unstructured environment where information is provided primarily by health plans. Although the Health Care Financing Administration (HCFA) is already making changes, such as providing more information in a comparative framework, more steps will certainly be necessary.

It is clear that the conditions critical to facilitating beneficiary choice are interrelated and that policies in one area affect those in others. Making available comparative information on plan options may be easier to accomplish if decisions are made in a structured enrollment process. Similarly, rules against marketing abuses will help protect beneficiaries from information that is biased or inaccurate, and wider availability of neutral information will itself be a protection against misleading marketing.

The best environment for informed decisionmaking probably involves some coordination of plans' open enrollment seasons. Although plans now must hold at least one open season each year, beneficiaries may never have an opportunity to compare all

This chapter includes:

- *Current system for enrolling and disenrolling beneficiaries*
- *Options for open seasons, enrollment rules, and disenrollment policies in a restructured Medicare*
- *Sources of information about Medicare options*
- *Development of new informational materials*
- *Marketing standards*

options simultaneously. Designing an enrollment process to meet these goals will require a series of decisions. First, should all plans' open seasons occur during a single annual enrollment period? Second, should Medicare beneficiaries' right to disenroll in any month be retained, or should they be locked into their choice of plans for a full year?

Although taking no position at this time on these critical issues, the Commission does support two rules in the event that the Congress eliminates the monthly option to disenroll. One is retention of the existing right of retroactive disenrollment, a policy aimed at circumstances where the plan's misrepresentation or the beneficiary's misunderstanding results in an enrollment that should not have occurred. The other rule would protect beneficiaries in circumstances where a plan makes a significant change in its network of providers during the lock-in period.

Regardless of how enrollment might be restructured, the Commission strongly supports the need for better information. Its recommendation reflects the fact that Medicare's ability to provide accurate comparative information to beneficiaries requires resources commensurate to this task. In addition to providing information on a plan's costs, benefits, and network of providers, the Commission has expressed a concern in past reports that beneficiaries be informed about the financial incentives that a plan places on providers. Disclosure of this information could help consumers make wise choices.

A final set of recommendations calls for continuation of current marketing rules designed to protect beneficiaries from practices that may easily lead to enrolling ill-informed beneficiaries or to encouraging risk selection. The Commission also calls for the use of standard definitions and a standard enrollment application, both steps that should further reduce chances for marketing abuses.

Recommendations

Under an expanded Medicare program, the current policy of retroactive disenrollment should be available to beneficiaries who fail to understand the consequences of their choice of a private health plan option.

If there is an annual lock-in requirement for beneficiaries and if a plan makes a major change in its network of providers during the year, beneficiaries should have the right to disenroll before year-end or to purchase services on a special point-of-service basis for the rest of the year. The exact circumstances under which such a policy would be invoked should be specified in regulations.

The availability of comparative information on plan options will be critical to ensuring meaningful beneficiary choice. Sufficient resources should be made available to support development and dissemination of informational materials.

Plans should disclose information about the general nature of the financial incentives faced by providers who contract with a health plan.

Explicit marketing provisions included in current regulations should be incorporated in any new regulations developed for private health plans participating in Medicare. These should include prohibitions on discriminatory marketing practices, misrepresentation of the Medicare program or the plan, door-to-door solicitation, and the giving of gifts or payment to prospective enrollees.

All marketing materials distributed by health plans participating in Medicare should use standardized definitions developed by the Secretary of Health and Human Services to the extent feasible.

The Secretary of Health and Human Services should provide an enrollment application as part of the comparative information package given to all beneficiaries.

This chapter addresses issues of facilitating beneficiary choice among a broader array of Medicare options. It first reviews current Medicare rules for enrolling and disenrolling beneficiaries in private plan options. It then summarizes arguments typically advanced for moving to some system of coordinated open enrollment, an approach the Commission endorsed last year. Next the advantages and disadvantages of different options for structuring open enrollment seasons and for allowing disenrollment are reviewed, both separately and in combination.

The final sections of the chapter address critical elements in the beneficiary's decisionmaking process: the availability of information about multiple plan options and marketing by plans. The former topic includes a review of empirical evidence on sources of information and how better information might be provided. The latter topic includes a review of current marketing rules and their ongoing importance as the program evolves, as well as recommendations for protecting beneficiaries from potential abuses.

MEDICARE'S CURRENT ENROLLMENT AND DISENROLLMENT POLICIES

Under the Medicare program today, beneficiaries generally learn about participating private health plans only as a result of marketing by the plans themselves. Although some general information on options is offered in different Medicare publications, these have not been broadly circulated. HCFA, however, has announced its intention to upgrade the information in its publications and to make them more widely available. The enrollment process is also heavily controlled by the plans, which provide beneficiaries with enrollment forms and inform Medicare about the beneficiary's intention to enroll. This section describes how enrollment and disenrollment work in the current program.

Eligibility

Nearly all Medicare beneficiaries are eligible to enroll in any local health plan that contracts with HCFA. Provided that beneficiaries live in a plan's service area, they can enroll if they are signed up for benefits

under Medicare Part B, do not have end-stage renal disease (ESRD), and have not elected to be cared for in a Medicare-certified hospice.[1] Plans are prohibited from screening prospective enrollees for any preexisting conditions other than chronic kidney failure and may not deny or discourage enrollment based on a beneficiary's health status. Plans are required to enroll all eligible beneficiaries in the order that applications are received, until their enrollment capacity is reached.

Beneficiaries must have Medicare Part B benefits before they can enroll in a health plan. For various technical reasons that concern HCFA's data system, there is often a time lag involved in establishing a record of participation in Part B. This lag may result in a one-month waiting period before new beneficiaries can opt to join a plan. This delay has caused some concern among plans and beneficiaries wishing to enroll in a plan at the time that they become entitled to Medicare.

Enrollment Process

Enrollment occurs during plans' open seasons. Plans must have at least one 30-day open season each year. They must also allow enrollment at other times to beneficiaries who have been disenrolled from other Medicare plans in the area as a result of contract termination or nonrenewal. Plans may offer any other open enrollment periods they choose. In fact, it is common for Medicare managed-care plans to have continuous open enrollment. This practice applies to all plans operating in HCFA's Region IX, which covers Arizona, California, Hawaii, and Nevada, and encompasses more than 50 percent of all Medicare beneficiaries enrolled in managed-care plans. Plans must notify the public in their service area (through various forms of media) of their open enrollment periods.

Enrolling in Health Plans. Beneficiaries generally enroll directly through the private health plans.[2] Although there is no standardized enrollment form, applications that plans provide to beneficiaries must comply with HCFA rules pertaining to content and format. For example, HCFA requires that enrollment forms explicitly cover any lock-in rules that limit plan liability for services received by beneficiaries from providers outside their plan's network. Enrollment forms must also inform beneficiaries of their appeal rights and premium requirements. Beneficiaries are required to initial a series of statements about their understanding of the terms of enrollment. They must also authorize the disclosure and exchange of necessary information between HCFA and the plan and sign the application form before the plan can file the enrollment with HCFA. At the time of application, the plans inform beneficiaries of their tentative enrollment date.

Enrollment information is provided to the central HCFA office by the plans, at which time HCFA verifies eligibility and processes the information. A Medicare beneficiary's enrollment begins on the first day of

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[1] The ESRD restriction does not apply for newly entitled Medicare beneficiaries with ESRD who wish to retain an existing membership in a health plan. If a beneficiary develops ESRD after joining a plan, the plan is responsible for arranging for care. Beneficiaries who elect hospice care for a terminal illness after joining a plan will receive hospice services from a Medicare-approved hospice and may continue their enrollment. If so, the plan must continue to arrange for services unrelated to the terminal condition. Plans may not initiate disenrollments in either circumstance, unless requested to do so by the enrollee.

[2] An exception to the rule of beneficiaries enrolling through the plans applies to plans that have both a Medicare risk contract and a contract with an employer group. In this situation, entitled group members (usually company retirees) who wish to enroll under the Medicare risk plan may do so through their employers (see Chapter 16).

the month in which membership in the plan is deemed effective by HCFA. Beneficiaries have the option of delaying their enrollment up to three months. Plans may not enroll a beneficiary earlier or later than the time period allowed by HCFA.

Notification to Beneficiaries. After HCFA processes the enrollment information, beneficiaries are notified by both the plan and the agency. Plans must notify beneficiaries promptly in writing of HCFA's acceptance or denial of the application. This notice includes the effective enrollment date, or, if denied, an explanation for denial.

HCFA also sends a reminder notice to beneficiaries informing them of their effective enrollment date and other information regarding the terms and conditions of their enrollment. The letter is designed in part to ensure that beneficiaries understand what it means to be enrolled in a health plan and to confirm that they indeed intended to enroll. It informs beneficiaries that they are locked into the use of plan providers and identifies exceptions to the lock-in rule for emergency and out-of-area urgently needed services. It also reminds beneficiaries of their right to appeal decisions made by the plan regarding covered services and to disenroll if they so choose. HCFA is revising this letter to make it more user-friendly.[3] Because of the mechanics involved in processing beneficiary enrollment applications, this letter is typically received by beneficiaries after their effective enrollment date has passed.

Disenrollment

Beneficiaries have the right to remain enrolled in plans as long as plans continue their contracts with Medicare. Plans may not in any way request or encourage enrollees to disenroll, unless beneficiaries lose their entitlement to Medicare Part B, fail to pay premiums or copayments, commit fraud or allow their membership cards to be abused, or permanently move out of the plan's service area.

Beneficiaries, on the other hand, have the option to disenroll from a plan at any time. They may disenroll through either their plan or any Social Security or Railroad Retirement Board office. Disenrollment is effective the first of the month after one of these offices has received the request.

Retroactive Disenrollment. There is also a process for retroactive disenrollment, an administrative procedure whereby the enrollee's status is "rolled back" from health plan enrollment to participation in traditional Medicare. This process is intended as a practical solution for those beneficiaries who have shown a lack of intent to enroll, that is, those who did not understand that they were enrolling in a health plan. Retroactive disenrollment may be granted when the enrollee, the plan, or both demonstrate flawed enrollment. This could be evidenced by beneficiaries who (1) do not cancel their supplemental insurance coverage or who purchase such coverage after enrolling in a plan, (2) continue to use out-of-network providers for nonemergency services after enrolling, or (3) ask HCFA about their enrollment in a plan after being notified by the agency of a change in their enrollment status.

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[3] The new version of the letter, designed with the help of a beneficiary focus group, substantially expands explanations of the implications of enrolling and provides suggestions for getting additional help. In addition to rewriting the text to make it easier for beneficiaries to understand, it is being printed in a larger size type. A Spanish version (and possibly other language versions) will also be made available. HCFA expects to use the new version of the letter early in 1996.

Retroactive enrollment is also used for properly enrolled beneficiaries who move permanently out of the plan's service area and fail to disenroll. Submission of bills for reimbursement from providers in the new location could constitute evidence of the need for retroactive disenrollment.

The date to which beneficiaries' insurance status is reversed is established based on the circumstances of the case. It could be rolled back to the date of initial enrollment or to a date on which the misunderstanding occurred (e.g., when out-of-plan services were obtained). When retroactive disenrollment occurs, plans are required to return any premiums paid by the enrollee and the capitation paid by Medicare for any month for which HCFA processes a retroactive disenrollment. Beneficiaries' claims for services delivered by nonnetwork providers or by the plan during this period are paid by Medicare, subject to traditional deductibles, coinsurance, and other benefit limitations. The policy issue of whether to retain retroactive disenrollment is further discussed later in the chapter.

Obtaining Medigap Policies after Disenrollment. Disenrolling from a private health plan and subsequently returning to traditional Medicare raises important issues concerning supplemental insurance (Medigap) coverage. Beneficiaries who dropped their Medigap policies after enrolling in managed-care plans could find it difficult to obtain similar policies once returning to traditional Medicare. If they are able to get supplemental coverage, they will most likely have to wait six months for the plan to cover preexisting conditions. It is unclear how well beneficiaries with Medigap policies understand the complexities involved in joining a health plan, dropping their Medigap, and trying to reacquire a Medigap policy if they leave the plan.[4]

REDESIGNING BENEFICIARY ENROLLMENT AND DISENROLLMENT

This section looks at options for structuring enrollment and disenrollment processes in order to help Medicare beneficiaries make choices. First, two alternatives are discussed for both the structure of open enrollment seasons and the rules for disenrollment. Second, the four possible combinations that policymakers may wish to consider are described. As these alternatives are weighed, it will be important to consider which processes create the best environment for making information more available and encouraging sound marketing practices.

The Medicare program does not have a coordinated open enrollment season for the private health plans with which it contracts. As such, Medicare differs from the common practice in the group insurance market, where employees select among the plans offered during an annual open season. The Federal Employees Health Benefits Program (FEHBP), for example, provides information to all federal employees each fall during a four-week open season from mid-November to mid-December. Many private employers follow a similar pattern, although the timing may vary. Medicare practice resembles more closely the individual insurance market, where there is no employer to structure or limit available choices.

[4] See Chapter 16 for a broader discussion of issues related to supplemental coverage.

The Commission last year, as part of its discussion of the Medicare risk-contract program, recommended that coordinated open enrollment be established to offer beneficiaries full comparative information on private plan options. During an open enrollment period, beneficiaries should be given objective comparative information on the structure of different plans, basic and supplemental benefits and premiums, participating providers, and plan performance.[5] Premium and benefit information should be standardized so that beneficiaries can understand clearly what their financial obligations would be under each option. This basic approach should make beneficiaries more aware of their Medicare options and improve their understanding of managed care in general. If properly designed, it should guide consumers in making appropriate choices among competing plans and between these plans and traditional Medicare.

Annual versus Continuous Open Enrollment Seasons

Restructuring Medicare's enrollment process requires a decision about how open enrollment should be scheduled. Although some believe a single annual open season is the best way to make information available, others argue that comparative informational materials could be circulated annually while plans set their own enrollment periods as they do today.

The first option would follow the most common practice in the private group market and provide one annual coordinated open season for all plans. All beneficiaries would select a plan during that season and only then; exceptions might be allowed for newly eligible beneficiaries, those who moved to a new area, and those who disenrolled from another plan. The second option would provide a scheduled time each year when updated comparative information would be made available and when each plan would be required to be open for enrollment, but would allow plans to accept new enrollees at other times they designated. For purposes of this discussion, this option is labeled continuous open enrollment—although plans might choose to limit their open seasons.

An annual coordinated open season would maximize the value of distributing updated comparative information to all enrollees. As is the case in employment-based systems, it would be a time when information would be made available. When this process occurs each fall for federal employees, newspapers run special supplements, privately published booklets are available at newsstands, advertising fills radio and television airwaves and the sides of buses, and neutral groups conduct seminars and radio call-in shows.

Health plans, while benefiting from the increased visibility, point out that a single open season may not work as well where all participants are not connected through a single employer. Without any equivalent to the work site or employee benefits counselors for sharing information and advice, this approach may be less valuable. In addition, concentrating enrollment at one point in the year might be an administrative and clinical burden for some plans. It might force them to hire temporary staff to handle inquiries during the open season and to process new enrollees when enrollment begins. Physicians and clinics would be hard-pressed to take initial physical histories and review medications for new enrollees. This approach would also prevent plans from continuing to build their enrollment year-round, an important consideration for start-up plans.

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[5] See Chapter 6 for a discussion of measuring and reporting on plan performance.

A continuous open season, as defined above, could still accommodate a coordinated informational process (in contrast to the current system). But it would permit plans to hold other open seasons when capacity permits. Plans could decide whether they wanted to accept enrollment year-round, as many do today, or whether they prefer more limited open seasons. This approach would have the drawback of allowing some beneficiaries to enroll at a time when information booklets were less current.[6]

Monthly versus Annual Disenrollment Alternatives for Beneficiaries

Issues around structuring disenrollment alternatives are more difficult than the timing of open seasons. Some argue that the annual lock-in provides a more stable enrollment base for participating plans and may help to reduce the potential for selection bias. Others oppose any change from today's right to disenroll in any month, because it denies beneficiaries the ultimate protection from a plan that fails to meet their needs.

The first approach is to continue Medicare's current policy of permitting beneficiaries to disenroll during any month, effective the first day of the following month. The principal alternative is an annual lock-in where beneficiaries must commit themselves to a health plan or traditional Medicare for a full year. The latter approach would likely incorporate exceptions, as discussed below, that would allow earlier disenrollment under specified circumstances.

The annual lock-in may reduce the opportunity for risk selection. The ability of a beneficiary to disenroll promptly following the onset of serious medical conditions (whether that decision is made purely by the beneficiary or encouraged, however subtly, by the plan) could contribute to adverse selection and higher costs for the traditional Medicare program, assuming adequate risk adjusters are not in place (see Chapter 15). Full-year enrollment may also encourage plans to invest more in preventive health services or screening of new enrollees, because it increases the likelihood that the plan will retain its members long enough to benefit from the eventual savings from reduced morbidity.

Strong arguments, however, are made by both beneficiaries and plans for retaining the monthly right of disenrollment. Many beneficiaries believe this right guarantees them the freedom to change plans if they are not satisfied with their care. The ability to vote with their feet provides protection against deterioration in the quality of member services or the care delivered. In fact, monitoring of disenrollments can serve as one indicator of a plan's success in meeting beneficiaries' needs. Finally, the ability to disenroll on a monthly basis may be particularly important when many beneficiaries are just beginning to understand the implications of new options.

Health plans have generally supported this policy as well, believing that retaining a disgruntled enrollee is a disservice to both the plan and the beneficiary. They point to data on the low rates of disenrollment under the current system as evidence that most beneficiaries are sufficiently satisfied to stay enrolled for a year or more. Plans also find that it is generally easier to recruit beneficiaries who know they have the right to leave at any time.

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[6] Newly entitled beneficiaries will generally face this situation in their first year of eligibility.

Combining Open Season and Disenrollment Policies

There are four ways to combine the policies described above. Policymakers considered most of these alternatives during the past year and are likely to continue doing so as the legislative debate over Medicare proceeds.

Annual Open Season with Annual Lock-In. The Medicare restructuring called for in the conference agreement passed in November 1995 (H.R. 2491) creates a MedicarePlus program that would consolidate enrollment for all private health plans participating in Medicare into a single annual open season. Enrollment decisions would be made in October and effective in January; beneficiaries would be committed to the health plan they selected for one year (although with an option to disenroll within the first 90 days). As noted above, this approach adopts the most common model for employer groups and may reduce opportunities for risk selection. But plans argue that clustering nearly all membership turnover at one time of the year will prove costly and that the annual lock-in will make recruitment more difficult. Additionally, although beneficiaries gain from having current comparative information, they oppose losing their ability to leave if unhappy with the plan.

Annual Open Season with Monthly Option to Disenroll. The Administration's Medicare proposal would restructure the system with an annual 30-day simultaneous open enrollment period for all plans, but where beneficiaries would retain the right to disenroll in any month. Although this approach would protect the interests of beneficiaries, it fails to address risk selection or plans' administrative concerns.

Continuous Open Season with Monthly Option to Disenroll. The third option generally retains Medicare's current practice. It could, however, be combined with a period each year when comparative information would be available and when open enrollment would be required. Plans could maintain additional open enrollment periods. This approach appears to be the preference of the managed-care industry. It potentially maximizes the opportunities to sign up beneficiaries, while reducing fears of committing them to a full year with no right to exit. The industry argues that this approach is particularly important since Medicare marketing is done on an individual basis, in contrast to the group marketing that characterizes much of the private sector. But this approach tends to maximize opportunities for risk selection.

Continuous Open Season with Annual Lock-In. Under the fourth combination of policies, beneficiaries would be required to enroll in plans for 12-month periods, with enrollment allowed throughout the year at plans' discretion.[7] This approach might be relatively acceptable to health plans, and it addresses the most serious aspect of risk selection by eliminating monthly disenrollment.

But this option has unique administrative issues that result from the overlapping yearlong enrollment periods that beneficiaries in each plan would have. The key issue is how plan premiums and other contract

[7] An alternative approach would combine the annual lock-in requirement with a system where enrollment would be scheduled for the first day of the beneficiary's birth month. This approach has similar advantages to the one described here, but would place more restrictions on how plans schedule their open seasons.

terms would be established. Under the current system, if a plan increases any supplemental premium (or reduces any offered rebate), beneficiaries may disenroll rather than incur the higher cost. Similarly, if a plan changes its benefit package, enrollees may reevaluate whether the plan serves their needs and disenroll if desired. With continuous enrollments for a one-year minimum period, it is unclear when plans should be permitted to change premiums or benefits and whether enrollees in the middle of their yearlong commitment should be given an opportunity to disenroll. The issue could be triggered when HCFA announces new payment amounts each year, and plans need to reevaluate the premiums they charge. In addition, some procedure would be needed to keep comparative informational materials current.

Transitional Issues. For options that differ considerably from current practice, transitional issues may also arise, especially if policy changes lead to substantially increased enrollment in private plans. For example, the Congressional Budget Office (CBO) has estimated that, under the terms of the conference agreement, 3 million new enrollees would join MedicarePlus plans in 1998 as a result of the first open season in October 1997.[8] Under this assumption, total enrollment in health plans in 1998 would be up 75 percent from the previous year's projected level, to 17.5 percent of all beneficiaries. CBO projects substantially smaller annual increases in enrollment after the first year (O'Neill 1995).

Large numbers of new enrollees could pose administrative and clinical burdens on MedicarePlus plans and on the Medicare program. For plans, tasks would include sending enrollment paperwork to Medicare, sending information packages to new enrollees, collecting baseline health information on new enrollees, and (in some cases) performing baseline medical exams. Medicare would need to process enrollment forms, send notices to all new enrollees, make risk-adjusted capitation payments to the plans, and ensure that fee-for-service payments for enrolled beneficiaries are not allowed after January 1. The potential consequences of a failure to complete these basic tasks could be serious. Beneficiaries and providers could face confusion over enrollment status, care might be delayed, plans might face cash flow or staffing problems, and the Medicare program might become inundated with complaints.

For these reasons, it might be advisable to modify the annual open season and lock-in rules envisioned in the conference agreement for the first few years. One approach would temporarily retain continuous open enrollment and monthly disenrollment, while disseminating comparative information on plan options at least once each year. The conference agreement already took this approach for a one-year transition, but it might be extended for another two or three years. This process could be further extended in those market areas where penetration remains too low to ensure stability and broad familiarity with plan options.

A second approach would stagger enrollment during the first few years so as to reduce the potential consequences of large first-year enrollments. For example, enrollment information could be provided during a common month, but enrollment applications could be accepted over a four-month period based on some criterion such as first letter of the last name. A six-month lock-in could be adopted, or disenrollment could be permitted only within 90 days or at the next open season. This approach would spread the impact of new enrollment while retaining the basic enrollment structure envisioned in the conference agreement.

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[8] About 500,000 of these new enrollees are projected to select plans with medical savings accounts, some of whom are assumed to enroll during 1997.

DISENROLLMENT ISSUES IN A RESTRUCTURED MEDICARE

If policymakers choose to reject the monthly right to disenroll that Medicare now provides and to adopt a general policy that permits disenrollment only during the annual open season, other disenrollment rules may be necessary to ease the impact of this policy. Even advocates of the yearlong lock-in would provide certain exceptions. Three rules are considered in this section. One would provide most beneficiaries with an unrestricted option to disenroll during the first 90 days after enrollment starts. Another would preserve the option in current law for retroactive disenrollment in circumstances where enrollment has occurred erroneously. The third would be broadly labeled as disenrollment for cause, such as the plan's violation of contract terms.

Disenrollment during the First 90 Days

Policymakers who favor the annual lock-in requirement recognize that some beneficiaries may decide after a short period with a private health plan that they have made a bad decision. If so, it may be in neither the plan's nor the beneficiary's interest to live with this decision for a year. The conference agreement, for example, addresses this concern by offering an unrestricted disenrollment option during the first 90 days, sometimes referred to as a "cooling off" period.

Under the rules proposed in the conference agreement, beneficiaries are limited to exercising this option twice in a year. They could select one plan and disenroll within 90 days, then select another plan and leave within 90 days of that decision. After each decision to disenroll, the beneficiary could return to traditional Medicare or choose another plan. A variant on this policy would allow the beneficiary to switch only to traditional Medicare until the next open season. The Administration proposal, as noted above, would retain the monthly right to disenroll; disenrollees would return to traditional Medicare until the next open season.

Data on patterns of early disenrollment offer some support for a 90-day disenrollment option.[9] Under current rules, 2.6 percent of enrollees leave within 90 days of joining. Yet a similar proportion (2.7 percent) of those who stay disenroll in the next 90 days. Only after six months does disenrollment start on a steady decline, falling to about 1 percent after the first 18 months and about 0.6 percent of those still enrolled after 30 months. Although most enrollees stay with a plan for an extended period, roughly one-third of all those who disenroll in a given time period do so in the first 90 days. Based on these data, it appears that the 90-day disenrollment rule offers beneficiaries a valuable protection. But it may force some beneficiaries to decide more quickly than they do today whether their trial enrollment is successful.

Retroactive Disenrollment

Although retroactive disenrollment is a relatively rare event, the Commission believes it to be an important protection for beneficiaries who have enrolled under false pretenses or whose request for disenrollment is

[9] This analysis examined rates of disenrollment during each month of enrollment for a cohort of beneficiaries who joined risk-contracting plans during 1992 and whose enrollment did not end because of death. The specific measure used is the proportion of those enrolled at the start of a specified time period who disenroll before that period ends (the conditional probability of disenrollment).

not handled on a timely basis. As discussed earlier in the chapter, retroactive disenrollment is an administrative procedure whereby an enrollee's status is rolled back to traditional Medicare from enrollment in a health plan. It offers an important complement to the general option to disenroll within the first 90 days because it allows beneficiaries who fail to understand the terms of enrollment to have claims for out-of-network care paid by Medicare. Provisions for retroactive disenrollment similar to existing procedures are included in the Administration proposal, but they are not specified in the conference agreement.

The number of retroactive disenrollments should not be high, since this is an exceptions process. It is not Medicare's intent that this status be granted routinely. HCFA found that in Region IX retroactive disenrollment occurred about 0.22 times per 1,000 members for the third quarter of 1996 (HCFA 1996).[10]

Special Disenrollment Rules for Midyear Changes in Plan Design

All proposals for restructuring the enrollment system, regardless of the lock-in rules, would allow certain disenrollments for cause. These might include situations where the plan has ceased to operate or has lost its Medicare contract, the beneficiary has moved out of the service area, or the beneficiary can demonstrate that the plan has violated its contract.

The issue of violating contract terms grows more complex if enrollees are locked in for a year. The conference agreement, for example, would establish Medicare's contracts with plans for at least one year.[11] Beyond the standards that would be enforced on all plans, it is not clear which plan features would be changeable within the contract year and which features would be locked in. It seems clear, for example, that a plan would not be permitted to change the amount of any additional premium it charges, any rebate it provides to beneficiaries during the contract year, or the benefit package it offers. Less clear, however, is whether it could restructure its network of physicians in the middle of the enrollment year or change the basic financial arrangements between the plan and its physicians (e.g., switch from capitation to fee-for-service with withholds).

From the perspective of the beneficiary, significant changes to the network of available providers may be viewed as a violation of contract terms by the plan when he or she has no option to disenroll and seek a different plan. If enrollees have difficulty locating acceptable providers in the revised network, they might be forced to pay out of pocket for the full cost of care.

The Commission proposes that, to preserve continuity of care, enrollees should have either the right to disenroll before year-end or to invoke a special point-of-service option for the rest of the year. The latter option would allow the beneficiary to be reimbursed without substantially higher cost sharing for services

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[10] This figure combines data for two categories: one, when a beneficiary denies being enrolled in a Medicare plan or alleges an incomplete understanding of the rules, and the other, when a beneficiary submits a disenrollment request that was not correctly processed.

[11] The conference agreement does not specify the timing of contract years. It would be logical for all plan contracts to run coterminous with the enrollment year.

obtained from providers removed from a plan's network other than for cause. Because of differences in plan design, it is not assumed that beneficiaries would necessarily have both of these options. Nor is it assumed that the separation of a single physician from the network would trigger this privilege; rather, it would apply only where a major change occurs in the provider network. Defining the precise circumstances under which this privilege would be available could be difficult and should be worked out in regulations implementing this policy.

INFORMING BENEFICIARIES ABOUT MULTIPLE HEALTH PLANS

Providing Medicare beneficiaries with a broader range of health plans is a key goal of Medicare reforms. The assumption behind this change is that offering more choice will enable beneficiaries to seek out arrangements that best suit individual needs. Plans will respond to beneficiary concerns, competing for enrollment based on a variety of factors including the supplemental coverage they offer, the reputation of their provider networks, customer service, and price. Ultimately, this competition is intended to result in a better match between consumer preferences and plan offerings than now exists. The previous section considered how changes in the enrollment process might offer a setting more conducive to making choices.

Effective competition assumes, however, that consumers have access to information about their choices and the ability to interpret that information. This section explores the challenges in developing policies that can meet this goal. It begins with a brief review of what Medicare beneficiaries know about their health care coverage and how they now learn about the options available. It then considers what will be needed, at least as an initial strategy, to educate these individuals as the available options expand. Both the content and methods of communication are addressed. Some additional steps are suggested to expand and strengthen educational efforts.

What Beneficiaries Know about Medicare Coverage

In order to choose among Medicare offerings, beneficiaries must understand the basic features of the options available. As a group, however, Medicare beneficiaries are poorly informed about what the program covers, the restrictions and limitations on coverage, and cost-sharing policies (Cafferata 1984; Lambert 1980; McCall et al. 1986). They are likely to underestimate the amount of expenses covered by Medicare, and a substantial proportion simply do not know whether various types of services (e.g., ambulatory physicians' services, inpatient psychiatric care) are covered. Limited knowledge about supplemental insurance policies has also been well documented, with the large number of individuals purchasing duplicate coverage being one of the primary reasons for Medigap reforms in the 1980 Baucus amendments and the Omnibus Budget Reconciliation Act of 1990 (GAO 1991).

Not surprisingly, Medicare beneficiaries have been found to be most aware of benefits for services most often used (McCall et al. 1986). Differences in knowledge vary based on beneficiary characteristics. Nonwhites and widows or widowers know less; those with higher education, higher incomes, or supplemental insurance coverage as well as the younger elderly are more knowledgeable. Findings on the

effect of sex and self-perceived health status on insurance knowledge have been ambiguous (Cafferata 1984; Lambert 1980; McCall et al. 1986).

The few studies of consumer knowledge that have been conducted focus on the traditional Medicare program and supplemental policies. There is little empirical work on understanding of managed-care benefits, likely reflecting the relatively small proportion of Medicare beneficiaries now enrolled in these plans. Advocates suggest, however, that beneficiaries have limited understanding of either how managed-care plans work (for example, that enrollees are restricted to a network of providers) or the specific benefits of particular managed-care plans.

Current Sources of Information about Medicare Options

Medicare beneficiaries are like other consumers in their limited understanding of their insurance coverage (Newhouse et al. 1981; Marquis 1983). This may reflect the fact that insurance terminology is by its very nature abstract and ambiguous (Davidson 1988). Lack of information on Medicare options from sources other than the plans themselves may contribute to poor understanding because people are left to work their own way through the maze of fee-for-service and managed-care policies.

Several sources of information about insurance options are now available to Medicare beneficiaries. These sources, described below, include HCFA, health insurance counseling programs funded through federal grants to state and county offices of aging, materials developed by advocacy groups, and marketing efforts by health plans. While these sources may be valued by consumers, each is somewhat limited. In fact, in many cases, beneficiaries rely on the advice of their physicians, friends, and family rather than objective data sources. In a series of focus groups conducted around the country in early 1995, word of mouth appeared to play an important role in choosing specific managed-care plans (Frederick/Schneiders 1995).

HCFA Efforts. HCFA now engages in a relatively modest effort to educate beneficiaries, telling them about their health plan options only when they first become eligible for Medicare. A variety of additional publications and videotapes explaining managed-care options can be obtained at any time upon request; some of these have been developed by the central office, others by regional offices. For example, Region IX has developed plan comparison sheets for three markets in that region, and HCFA is preparing to expand this effort to other regions.

Health Insurance Counseling Programs. Other sources of information are health insurance counseling programs funded by HCFA via grants to the states. In general, these are small-scale operations, often staffed by volunteers. They offer one-on-one counseling to Medicare beneficiaries about their options for supplemental insurance and managed care, as well as troubleshooting on other issues. In fiscal year 1995, $10 million was distributed based on a formula related to the number of Medicare beneficiaries residing in each state. These programs are well-regarded for providing accurate information but reach relatively few beneficiaries.[12]

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[12] During a one-year reporting period (April 1, 1993-March 31, 1994), these programs served about 1 percent of individuals over the age of 65 (Cronin 1995).

Advocacy Groups. Beneficiary advocacy groups, such as the American Association of Retired Persons and Families USA, have developed pamphlets, videotapes, and other materials concerning Medicare managed care. Typically, these materials focus on generic issues (e.g., explanation of the concepts of managed care or the types of Medicare managed-care arrangements) rather than providing information on particular plans. Another type of educational product is a resource list that directs beneficiaries to local agencies or other private organizations that can help resolve specific problems. Although such efforts are useful to many beneficiaries, they are not intended to reach all beneficiaries or to be used as the basis for selecting plans.

Health Plans. Health plans are another source of information about insurance options, reaching a large number of beneficiaries through both mass media and seminars. While beneficiaries attending plan-sponsored seminars can learn a great deal about that plan, these seminars are marketing efforts and are not intended to provide an objective comparison of competing plans. In fact, in focus groups of Medicare beneficiaries, many have expressed worry about the objectivity of this information (Frederick/Schneiders 1995).

Informing Beneficiaries under an Expanded Set of Options

Currently, Medicare beneficiaries have few sources of information about their options and must work quite hard to learn about the plans available in their community. Under the conference agreement, substantially more information would be provided to them. Information would be made available to beneficiaries in two ways: printed materials provided to all eligible individuals by mail prior to the annual open enrollment season and a toll-free telephone hotline. The legislation specifies that printed materials shall be written and formatted in the "most easily understandable manner possible and must include a list of plans, a comparison of plan features, and the Medicare capitation rate."[13] The Secretary is also given broad authorization to disseminate information on coverage options to promote "active informed selection." These activities would begin with a nationally coordinated educational and publicity campaign to inform beneficiaries about available health plans to be held prior to the first year's open season. The Administration proposal for broadening the options available under Medicare also calls for the Secretary to develop and distribute standardized comparative materials on plan options.

These plans are ambitious given Medicare beneficiaries' low level of knowledge about their current coverage, their limited experience with managed care, the anticipation of greatly expanded offerings in many markets, and HCFA's experience in providing information. Moreover, the processes of presenting useful information and selecting the plan that offers the best value will be particularly challenging under the conference agreement because supplemental benefits would not be standardized across plans.[14] Still to

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[13] Specific information to be included in the comparison chart includes benefits beyond those covered by traditional Medicare; reductions in beneficiary cost sharing and limits on out-of-pocket spending (but interestingly not policies that could increase beneficiaries' financial liability); premiums; quality indicators including disenrollment rates, enrollee satisfaction, and health outcomes; and offering of supplemental coverage.

[14] By contrast, the Administration proposal outlines plans to work with the National Association of Insurance Commissioners to develop an approach for standardizing supplemental benefits offered by managed-care plans.

be tackled are the critical steps of (1) developing materials responsive to beneficiary needs, (2) devising ways to disseminate information that help improve beneficiary knowledge, and (3) providing sufficient resources to accomplish these goals. These issues, relevant to any effort to offer multiple options to Medicare beneficiaries, are discussed below.

Because many employers, both public and private, now offer multiple insurance options, lessons from their experience are drawn upon where appropriate to this discussion. It should be noted, however, that not all of these approaches may be transferable to the Medicare population. First, tools that work for informing employees as a group may not work for Medicare beneficiaries, for whom no benefits manager serves as a central agent. In addition, materials and approaches used for the employed population may not be well-suited to the elderly. Older people differ from young adults in how they process information. They find it harder to process information when it is new or complicated, when it is externally and rapidly paced, and if irrelevant and relevant information are mixed (Davidson 1988).

It is also worth noting that, although segments of the employed population may have access to more systematic information than now provided under Medicare, many employers characterize their educational efforts as still in the first generation. Employees have also noted that the information given to them leaves much to be desired. For example, in a series of focus groups with middle-income privately insured persons conducted for the Michigan Peer Review Organization, "many participants indicated that they had a choice of health care plans but did not have a great deal of information on which to base their decisions." Among these individuals, word of mouth was the most frequently named factor in determining plan selection (Public Sector Consultants 1995).

Developing Materials. Both the conference agreement and the Administration proposal envision annual dissemination to all beneficiaries of a booklet prepared by the Department of Health and Human Services comparing plans available in their market. In developing this publication, several questions must be addressed: what information will be needed to facilitate informed choice, how much of this information is now available, and who is the target audience?

The first issue is determining the specific features to be compared. The conference agreement sets out a long list of plan features to be included in the comparison booklet. Although this list provides a starting point, other types of information will also be desirable. Among these features are beneficiaries' potential liabilities for balance billing associated with out-of-plan use (whether referred or under point-of-service options), provider directories with information on physician credentials and practice sites, and a general description of the financial incentives faced by a health plan's providers.[15]

Although some information necessary for comparing plans can be readily obtained from plan brochures (e.g., supplemental coverage offerings), other data require more time, effort, and interpretation. For example, out-of-pocket costs can be characterized by simple percentages or fees (i.e., 20 percent of the plan payment or $5 per physician office visit). Other ways of presenting this information, however, may

[15] See Chapter 16 of the Commission's 1995 annual report and Chapter 15 of the 1989 annual report for previous discussions of the need to provide information on financial incentives (PPRC 1989; PPRC 1995).

promote more informed choice. One approach used in the *Washington Consumers' CHECKBOOK* guide for federal employees is to estimate approximate annual out-of-pocket costs under various assumptions about spending (Francis 1995). Another approach found to increase beneficiary knowledge about coverage and influence decisions about spending is to display out-of-pocket spending that would be typical for a given diagnosis.[16] To do so, however, requires selecting conditions with a relatively high consensus regarding appropriate diagnosis and treatment protocols, agreement on a course of care, and assignment of costs based on information about what plans pay for those services (Sofaer et al. 1992).

Measures of plan performance that may be desirable for beneficiaries choosing among multiple health plans are now being developed as part of the Health Plan Employer Data and Information Set (HEDIS). They include consumer satisfaction with various aspects of the plan (e.g., quality of care, access, availability of providers, ease of filing claims, customer service); process measures (e.g., rates of mammography screening); and outcomes measures (e.g., mortality rates for certain conditions). There are two challenges for the Medicare program's use of HEDIS. HCFA is dealing with one—the development of measures appropriate for an elderly population. The other is collecting and analyzing comparable data from plans and beneficiaries, either through surveys or encounter data (see Chapter 6). For example, both FEHBP and the state of Minnesota have mounted special surveys focusing on different aspects of consumer satisfaction to inform plan selection. Interestingly, although consumers rely heavily on the advice of peers in selecting plans and providers, many are skeptical about the validity of consumer satisfaction ratings and efforts to quantify quality of care (Public Sector Consultants 1995; Frederick/Schneiders 1995).

As for a target audience, it is clear that a publication should speak to the needs of elderly and disabled populations. It is important to recognize, however, that Medicare beneficiaries are a diverse group and that differences in health status, family situation (whether living alone), educational level, and income will affect the types of information that might be most meaningful in selecting a plan. Just as beneficiaries themselves are most knowledgeable about the services they use, they are most interested in information related to these services. That is, someone with a chronic disease may be concerned about access to specialists, while another person with functional disabilities may want to know more about home care policies. Others may require information in languages other than English or written for low literacy levels. Although it would be unrealistic to develop booklets to address the needs of all identifiable subgroups, one size will not likely fit all.

Also of concern are the format and graphic presentation of plan-specific information. At issue is how to make materials user-friendly without obscuring important but sometimes quite technical points. In developing materials to support plan selection for Minnesota State employees, the Department of Employee Relations consulted extensively with both graphics experts and state employees on how best to present comparative information. Even seemingly minor issues, such as use of color and whether bar graphs appear vertically or horizontally, seem to affect understanding. Focus groups conducted among the privately insured in Michigan also found substantially different reactions to various report card formats (Public Sector Consultants 1995).

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[16] In a study testing use of this approach as part of a workshop on plan selection, those exposed to this "illness episode" approach were more likely to drop duplicative coverage, spend less on premiums, and report that decisions to change coverage had met their expectations than beneficiaries exposed to more traditional characterizations of out-of-pocket spending (Sofaer et al. 1992).

Developing Methods of Communication. Developing a booklet to compare plan features will be only the first step in a process of educating consumers about their options. Although distribution of printed materials is the most typical form of insurance education, printed information alone tends to be the least effective method of educating consumers (Davidson 1988).

A variety of conduits could be used to educate Medicare beneficiaries about their options; research provides little help on identifying the most effective approaches (Sofaer et al. 1992). It has been shown that an approach that first lets beneficiaries know what information they need and what educational services are available, and then provides the actual education in an interactive personal format, works better than just providing printed information (Schauffler 1980). Moreover, different methods may work better for different types of beneficiaries (Andrews et al. 1989).

These two findings suggest the need for offering information to Medicare beneficiaries in multiple formats. In addition to brochures, printed materials may include workbooks that help beneficiaries calculate their expected out-of-pocket costs based on prior use. Other media include videotapes and radio and television broadcasts.

A disadvantage of pamphlets and videos is that they are not interactive, and thus neither format reinforces knowledge nor allows exploration of topics of personal interest.[17] Interaction can take several forms, including toll-free hotlines, personal counseling, and workshops. Workshops sponsored by neutral parties have increased understanding of Medicare and other insurance, and have improved satisfaction with cost of health care coverage (Sofaer et al. 1992).

Computers offer the advantage of "layering information," allowing people to pursue topics of special interest easily without being overwhelmed by extraneous material. HCFA has contracted with CompuServe to provide online access to its publications and to maintain a seniors forum allowing online access to staff from HCFA's Office of Beneficiary Relations. Medicaid has used touch-screen computers known as kiosks to help beneficiaries make choices among managed-care plans. It is unclear whether this technology would be as useful for the Medicare population. First, there is no one location for these kiosks (comparable to the welfare office for Medicaid) where beneficiaries go on a regular basis. Second, lack of familiarity with computers may make this method more daunting to the elderly and disabled, although this will likely change over time.[18] The Social Security Administration is now conducting a pilot kiosk project that includes some information on Medicare. The project will be evaluated later this year for replication in other sites (Cronin 1995).

Providing the Resources to Educate Beneficiaries. The success of any educational effort will depend upon the resources available. Private employers report that educating retirees requires considerably more time and resources than active workers. When using telephone hotlines, retirees typically spend far

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[17] In focus groups of Medicare beneficiaries, videotapes were not viewed positively because they prompted questions that could not be answered (Frederick/Schneiders 1995).

[18] An estimated 9 percent of people 65 years or older now use a personal computer at home (Templin 1995).

more time asking questions—both because they are less familiar with newer benefit options and because they have more time to devote to making inquiries. One corporate benefits manager offered a rough estimate that the company spends $75 per retiree annually to provide materials and counseling—a substantial sum if applied across the entire Medicare population.

Because the availability of comparative information on plan options will be critical to ensuring beneficiary choice, the Commission recommends that sufficient resources be made available to support development and dissemination of informational materials. The conference agreement provided no funding for the plan comparison booklet and toll-free hotline. Given that HCFA has long argued that it lacks sufficient funding to send a *Medicare Handbook* to all beneficiaries annually (a cost of about $18 million to $20 million), producing a plan comparison booklet in a timely fashion seems unlikely. Other activities that might need funding include expanding insurance counseling programs and mounting a consumer satisfaction survey.[19]

In conducting its consumer satisfaction survey for FEHBP, the Office of Personnel Management (OPM) required participating plans to pay for the surveys associated with their enrollees. Legislation would likely be needed to give the Medicare program similar authority; such authority is provided in the Administration's Medicare restructuring proposal. This approach has the advantage of reducing the federal commitment but may be viewed as compromising the integrity of the product. In Minnesota, carriers and plans are not permitted to contribute to the costs of preparing surveys or information booklets for this reason.

Steps for the Future

Much remains to be known about how to help Medicare beneficiaries make an active informed selection among plans. Effective implementation will likely require tempering expectations about the ability of beneficiaries to choose wisely and providing funding necessary to launch a credible educational effort. Just producing a comparison booklet for each market and mailing it to as many as 37 million beneficiaries in time for an open season will be no small task.

Long-term prospects are more favorable. HCFA and the Agency for Health Care Policy and Research (AHCPR) have both initiated efforts to improve understanding of how consumers select among health plans and what information they find useful in making such decisions, as well as to develop various tools to aid decisionmaking. Some of these projects are directly targeted at the Medicare population. Lessons from others could probably be applied with some modifications.

As part of HCFA's plan to test competitive bidding in three market areas, a contract has been awarded for designing educational materials and developing a strategy for educating beneficiaries about the goals of these demonstrations, the concepts of managed care, how an open season works, and the features of available plans. In addition, the contract will explore how to implement the strategy in a cost-effective manner. The competitive bidding demonstration is scheduled to begin in October 1996 if authorizing legislation is enacted.

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[19] Staff members in HCFA's Office of Managed Care have begun discussing the use of consumer satisfaction surveys in the risk program. Options include adding questions to the Medicare Current Beneficiary Survey and conducting special surveys.

HCFA's Office of Research and Demonstrations has also funded a study by researchers at the University of Wisconsin on how consumers under 65 make decisions about health care coverage and what role their knowledge and information about health plans play in this process. A computerized data collection system will be tested to elicit consumer preferences and track their information search.

Along with these large efforts, HCFA is engaged in a number of more modest activities affecting beneficiaries. The Office of Managed Care is conducting a series of focus groups to evaluate what types of information beneficiaries want, what format is most useful, and how information can be improved. Additionally, the Office of Beneficiary Services has awarded a contract to evaluate the content, design, and distribution of all its publications. This effort also incorporates focus group feedback.

AHCPR has launched a major project, the Consumer Assessment of Health Plans study, to explore consumers' use of information and their ability to evaluate alternatives. Awards have been made to create survey instruments for different populations (adults, children, Medicaid beneficiaries, the chronically ill, and the disabled). Grantees will develop and test the effectiveness of different formats and evaluate the usefulness of this information in assisting consumers and purchasers in making informed selections.

AHCPR has also awarded contracts to several small businesses to develop innovative technologies for making informed choices about plans and providers. Funding has been provided to firms producing report cards, printed materials and videotapes for minority and underserved workers, and interactive computer-based systems. Using AHCPR funds to develop and test prototypes, these firms will then try to make these products commercially successful. Finally, the agency is working on a managed-care guide in cooperation with the Health Insurance Association of America to help consumers understand how managed-care plans work, and how to make informed decisions when choosing and using health plans.

It remains unclear whether a market for comparative information about Medicare plan options will emerge. If it does, this could take some of the burden off the Medicare program. For example, the *Washington Consumers' CHECKBOOK* guide to FEHBP provides substantially more comparative information than OPM's guide. This annual publication is available by mail and at retail outlets in the Washington area for less than $10. Relying on the market, however, does not ensure that such publications will be available in all markets where Medicare beneficiaries live. In fact, the *Consumers' CHECKBOOK* guide had a circulation of just 18,000 in 1994, whereas there were 9 million enrollees in FEHBP.[20] Moreover, given the substantial investment of federal dollars in the Medicare program, one could argue that the program has a duty to provide the information considered essential to making informed choices.

MARKETING BY HEALTH PLANS

Efforts to broaden choices in Medicare will place new pressures on plans to market themselves to beneficiaries. Under current Medicare policies, health plans are responsible for distributing information to

[20] Obviously, more than 18,000 federal employees and retirees had access to these guides but the exact number who did is unknown.

beneficiaries in their service area. New ways to structure open seasons and to provide comparative informational materials may in the future change the context for marketing efforts.

HCFA's regulations dictate to a degree what plans can and cannot do as they seek to attract enrollees. Plans are required to market their products throughout the entire service area specified in the Medicare contract and to provide beneficiaries with HCFA-approved descriptions of their benefits, fees, and all terms and conditions of membership. A number of marketing activities are prohibited. For example, plans may not engage in discriminatory marketing practices, such as those intended to recruit only healthier beneficiaries or beneficiaries from higher-income areas. Activities that could mislead or confuse beneficiaries or misrepresent the plan or HCFA are also banned. An example might be a claim that HCFA endorses a particular plan or recommends that beneficiaries enroll in that plan. In addition, door-to-door solicitation and the offering of gifts or payment for the purposes of enrolling beneficiaries are illegal.

Current System for Reviewing Marketing Materials

HCFA, primarily through its regional offices, is responsible for oversight of marketing activities. All marketing materials, including television, radio, and newspaper advertising; scripts for informational seminars hosted by plans; and all written material to be distributed to beneficiaries, must be submitted to the HCFA regional office in which the plan operates at least 45 days before their intended use. (An exception to this rule is discussed below.) HCFA primarily reviews the materials for accuracy, misleading or difficult-to-understand information, and inclusion of information that is required by law. The materials can be distributed after 45 days so long as the Secretary has not disapproved of their use; in other words, the Secretary does not need to actively approve the materials.

Plans that serve beneficiaries in more than one region must submit their marketing materials to each regional office. In this situation, HCFA attempts to coordinate the sharing of comments among regional offices.

The conference agreement would continue the current policy of requiring submission of marketing materials for review 45 days prior to distribution. It also contains a provision that would ease review requirements on plans serving more than one area. This would allow a plan whose marketing materials have been approved by one regional office to use them in another region served by the plan, thus eliminating the need to submit the same materials for approval in each region that the plan serves.

No systematic information exists with respect to the frequency that marketing materials are rejected. Officials in HCFA regional offices suggest that, while occasional problems arise, submission of faulty materials by plans is not a major concern. Some have noted that plans with recently awarded Medicare contracts experience the greatest problems in developing appropriate marketing materials. Problems may result from these plans' lack of familiarity either with HCFA standards or with serving Medicare beneficiaries (and thus in designing marketing materials for elderly populations). Officials also report that problems may arise from new plans' eagerness to begin marketing quickly to prospective enrollees. In general, they are especially concerned about areas where there is fierce competition and where plans may become more aggressive in their marketing tactics.

The lack of widespread problems may reflect most plans' desire to adhere to marketing rules. For obvious reasons, plans want the review process to be as smooth as possible, so they have a great incentive to follow marketing guidelines. Having materials rejected means that plans must revise and resubmit the information to HCFA. Region IX has implemented an incentive program known as "file and use" for plans that have submitted marketing materials in accordance with HCFA guidelines 95 percent of the time. This program allows eligible plans to use marketing materials without waiting for HCFA approval. Plans must continue to forward all materials to the regional office, and HCFA subsequently reviews the information. HCFA retains the right to remove a plan from the incentive program at any time, in which case the plan would revert back to the customary review process.

The switch to an annual open season envisioned in the conference agreement may complicate the process of getting approval for materials. Under this system, HCFA regional offices could experience a backlog as plans submit marketing materials for approval during a pre-enrollment season "rush." One option would be to switch to a file and use system where plans could use materials until such time as they are disapproved. This could be done on an incentive basis along the lines being used in Region IX. Because file and use rules may increase the likelihood of misleading materials being used, another approach would be to continue the 45-day review process while ensuring that HCFA has adequate resources for reviewing materials promptly.

Problems with the Existing System

Although several provisions now exist to protect beneficiaries against abusive marketing practices, beneficiary advocates and government officials have identified a number of concerns that relate to the current marketing and enrollment structure. In general, beneficiaries wishing to enroll in a health plan must make contact with the plan (e.g., through an enrollment seminar) to fill out an enrollment application. This system may leave some beneficiaries unsure about what plans are available to them or how to enroll. Beneficiaries may be encouraged to enroll on the spot, even though this could be their first contact with any plan. Sales representatives are also allowed to visit with beneficiaries one-on-one, provided that beneficiaries have permitted the representative to meet with them. A personal visit such as this may be initiated by the plan in response to a beneficiary's phone call requesting information. Such arrangements are highly vulnerable to marketing abuse, as it is virtually impossible for HCFA to monitor this type of personal contact. The relatively high level of disenrollments within the first 90 days for some plans or markets provides evidence that misinformed and inappropriate enrollments take place (Dallek 1995).[21]

Many abusive marketing practices stem from a system of using sales agents, often paid on commission, to market to and enroll beneficiaries. Minimally trained marketing agents have been accused of providing misinformation. Although plans are required to give beneficiaries written information on lock-in requirements, emergency and out-of-area care coverage, appeal rights, and grievance procedures, agents may not always fully explain these terms and conditions. For example, in a study on beneficiary

[21] Although only 0.7 percent of all enrollees in northern California disenrolled in the third quarter of 1995, 40.7 percent of these disenrollments occurred in the first 90 days of a person's enrollment. In southern California, where Medicare risk contracting was more established, about 1.0 percent of all enrollees disenrolled, but only 18.7 percent of them were in the first 90 days after enrolling (HCFA 1996). Similar differences were also found for the first quarter of 1995.

perspectives on Medicare risk-contract plans, the Office of the Inspector General found that one-fourth of beneficiaries said they were unaware of their right to appeal their plans' refusal to provide or pay for services. Coinsurance and other out-of-pocket costs, as well as plan performance indicators or customer survey results, may also be misrepresented by plan marketing agents (Brown 1995).

Abusive marketing practices stemming from a general lack of understanding or confusion about Medicare and managed care may be corrected through the provision of standard comparative information, as described earlier in this chapter. In addition, a number of recommendations have been proposed by beneficiary advocacy groups to help curb marketing abuses. These include requiring marketing agents to pass a HCFA-approved training program and written examination and prohibiting the payment of commissions to marketing agents if a new enrollee disenrolls within three months of enrollment. Another recommendation urges HCFA to strengthen enforcement of marketing rules through fines against the plan for each confirmed case of marketing fraud (Dallek 1995).

New Guidelines for Marketing Materials

In an attempt to expedite the review process and to achieve greater consistency among marketing materials, some HCFA regional offices have distributed marketing tips and guidelines to Medicare managed-care plans operating in their regions. The guidelines generally address problem areas that HCFA has identified in reviewing plan materials and make suggestions for ways to avoid these pitfalls. As an example, HCFA has issued a marketing tips guide that includes wordings that are suggested for use or have been deemed unacceptable (along with the rationale for them). In suggesting how plans might explain "lock in" in their materials, HCFA suggests: "You must receive all routine care from plan providers," or in a more expanded version, "If you obtain routine care from out of plan providers, neither Medicare nor the Plan will be responsible for the costs." Another example is that plans cannot use the term "plan representative" whenever beneficiaries are invited to attend a group session designed to enroll those individuals attending. Instead, the plan must use "sales representative" (HCFA 1993).

In response to the need for more consistency among regional offices in the review and approval of marketing materials, HCFA, in cooperation with the Group Health Association of America, is currently working on the development of national marketing guidelines and model materials. Such guidelines are intended to ease the review process, and, because there will be more consistency across regions, may benefit plans that operate in more than one region. In addition to marketing tips, the national guidelines work group is developing other model materials, including (1) annual notification letters; (2) enrollment, denial, and disenrollment letters; (3) evidence of coverage notices (the contract between the plan and the enrollee, which explains the enrollee's rights, benefits, financial liability, and other responsibilities, as well as the responsibilities of the plan to the enrollee); and (4) summary of benefits notices.

In the Commission's view, these HCFA initiatives represent a step in the right direction. The Commission has proposed that one way to ensure protection from marketing abuses would be to require plans to provide standardized, easy-to-read information in their marketing materials and at all presentations where the rules of enrollment and plan membership are described. Standardized marketing materials might ease the review process as well as reduce concerns about misinformation presented in marketing materials

distributed by plans. Once developed, standardized explanations and definitions of key concepts such as lock-in, emergency services, requirements for referrals to specialty care, and out-of-area coverage should be included in marketing materials distributed by health plans.

Marketing Provisions under a Restructured Medicare Program

Existing beneficiary protections against abusive marketing practices should be preserved under a restructured Medicare. The conference agreement calls generally for the establishment of new standards, including those for marketing, for MedicarePlus plans (see Chapter 3). New marketing standards, which would include guidelines for the review of all materials, would replace current standards for Medicare risk plans.

If current law is replaced, the accompanying regulations would presumably be phased out as well. Many of the prohibited marketing practices (such as discriminatory marketing practices, misrepresentation of the Medicare program or the plan, door-to-door solicitation, and the giving of gifts or payment to prospective enrollees) are specified in regulation rather than in law. Rescinding them would create the potential for increased abuse. In order to preserve such beneficiary protections, the Commission recommends that explicit marketing provisions included in current regulations be incorporated in any new regulations developed for private health plans participating in Medicare.

Enrollment through Plans or the Secretary

The conference agreement and the Administration proposal differ with respect to who would be responsible for enrolling and disenrolling beneficiaries. Under the conference agreement, beneficiaries would continue to submit enrollment and disenrollment applications through plans. This approach mirrors current policy and thus carries with it the same advantages and drawbacks. For example, having plan-level enrollment offers more administrative flexibility and can facilitate the process for plans. They can verify the information on the form with the beneficiary and reduce the number of errors that HCFA must address. The current system of enrolling beneficiaries through plans, though, is vulnerable to abusive marketing and sales practices by some plans. Even though regulations and oversight activities exist, enforcement of the law appears to be a difficult task when it comes to monitoring plan-to-beneficiary contact.

Provisions in the conference agreement for increased beneficiary education and awareness about MedicarePlus plans may help curb problems associated with enrollment. Enrollment through plans may become less contentious as beneficiaries gain a better understanding of the implications of their decision to enroll.

Enrollment through the Secretary of Health and Human Services, as proposed by the Administration, would be one way to diminish potential problems that might arise from some methods used by plans to recruit enrollees. For example, it would be harder for plans to enroll people at marketing seminars during their first contact with the plan. The risk of this approach, however, is that the additional administrative duties on the part of the Secretary could lead to delays in processing applications and result in confusion over payment and eligibility for services. If this proposal were adopted, it would be critical to provide adequate resources to the Secretary to handle these responsibilities.

A further complication is that plans sometimes accomplish other business as part of the application process. For example, beneficiaries often choose their primary care physicians and pay premiums at the time they file enrollment applications with plans. To deal with this, beneficiaries might be required to contact the plan of their choice to make these arrangements before filing an application with the Secretary. More generally, Medicare might need to establish a special enrollment hotline to answer questions during the enrollment process.

Standard Enrollment Application

Another way to address some enrollment-related concerns is to model the process after employer practices. As part of the informational package that includes plan comparisons, Medicare should provide beneficiaries a standard enrollment form and instructions for how to enroll in the plan of their choice. This step would ensure that all beneficiaries are given the opportunity to select a health plan without relying as heavily on direct contact with each plan. Doing so would be possible only if all plans used the same enrollment application. Such a process would also help beneficiaries who are unsure about how to enroll or who may be hesitant about attending plan enrollment seminars.

Providing all beneficiaries a standard enrollment application somewhat lessens the importance of whether the plan or the Secretary should receive the enrollment application from the beneficiary. Regardless of who handles the application, a beneficiary could be encouraged to contact his or her chosen plan to discuss the application before submitting it. It is likely that plans would continue to host enrollment seminars that beneficiaries could attend to learn more about the plan. Plans could distribute the standardized enrollment form at those sessions. As a result, many current marketing and enrollment practices could continue, but beneficiaries would have more options for how they obtain information and apply for enrollment.

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Medicare Capitation Payments

One of the key elements of recent legislative proposals to restructure the Medicare program has been the design of the payment method for private health plans contracting with Medicare. The ultimate success of any legislation intended to broaden options for beneficiaries will depend at least partly on the capitation rates paid to participating plans. The levels and predictability of payment rates rank high among the factors that influence plans' decisions to participate in Medicare. Payment policy affects beneficiaries' participation in health plans through its influence on the availability of plans in local markets, the amount of cost sharing, and the richness of supplemental benefits.

Medicare risk-contracting plans are the most widely used of the managed-care options currently available to beneficiaries. Medicare pays risk plans using county-level monthly capitation rates that are calculated each year at 95 percent of the counties' adjusted average per capita costs (AAPCCs) in the Medicare fee-for-service sector. The levels of these payment rates vary widely across counties, and payments in many smaller counties are volatile over time. These characteristics have contributed to uneven participation by health plans and beneficiaries across the country.

The Commission examined these issues in its *Annual Report to the Congress 1995* (PPRC 1995). To strengthen the risk program, it recommended methods to correct some of the shortcomings of the current payment rates. It also suggested an approach for introducing competitive bidding as a method for setting Medicare payment rates that reflect local market conditions.

The major proposals for restructuring Medicare submitted in the 104th Congress would broaden the choice of plans for

This chapter includes:

- *Problems with the current Medicare capitation payment methods*
- *Policy options and issues for designing a new capitation payment method*
- *Current legislative proposals for new capitation payment methods*
- *Estimated effects of proposed payment methods*
- *An approach to monitor the effects of a new capitation payment method*

beneficiaries and would establish one capitation payment method to pay all forms of plans. The conference agreement passed by the Congress in November 1995 (H.R. 2491) would use the 1995 AAPCC rates as the baseline capitation rates. It also had provisions that would correct some of the problems with the baseline AAPCC rates and uncouple capitation rates for succeeding years from Medicare fee-for-service expenditures. A proposal prepared by Senator Thomas Daschle would modify the payment method in the conference agreement. The Administration has endorsed the Daschle proposal, after having earlier proposed continuation of the AAPCC payment method with some modifications (House Document 104-160).

This chapter begins with a description of the current AAPCC payment method and some of its problems. It then examines policy options and issues for designing a new capitation payment method. This is followed by a description of the payment methods specified in legislative proposals and an analysis of their potential effects on payments. Recognizing that payment proposals still are evolving as the legislative debate continues, the analysis focuses on the key policy issues raised by different payment methods. This is intended to help clarify the implications of various options for a new Medicare capitation policy, without drawing conclusions about any single proposal. The last section describes an approach to monitor how changes in payment methods affect participation in private health-plan options and Medicare costs.

CURRENT PAYMENT POLICY FOR THE MEDICARE RISK PROGRAM

The Medicare risk-contracting program, which was authorized by the Tax Equity and Fiscal Responsibility Act of 1982, gives Medicare beneficiaries the option to enroll in health maintenance organizations (HMOs) and competitive medical plans.[1] These plans must offer Medicare-covered benefits, for which Medicare pays them a fixed capitation rate each month for each Medicare enrollee. Most participating plans also offer reduced cost sharing and coverage of supplemental services, for which they may charge enrollees an additional premium. These additional benefits serve as alternatives to private supplemental insurance, or Medigap, policies.

Participation in the risk program by health plans and Medicare beneficiaries has grown since its inception. The number of risk-contracting plans reached more than 140 by 1988, decreased to fewer than 85 in 1991, and has since increased substantially. At the same time, enrollment in Medicare risk plans has grown steadily. As of mid-1995, 167 plans had risk contracts and 7.3 percent of Medicare beneficiaries were enrolled in those plans. By the end of 1995, the number of participating plans had grown to more than 185 and enrollment had reached 8.8 percent of beneficiaries.[2]

Several inadequacies of the Medicare capitation payments are thought to have contributed to limited participation by health plans in some areas, overpayment of plans in other areas, and uneven enrollment

[1] Only beneficiaries who are Medicare-eligible due to old age or disability may choose HMO enrollment. End-stage renal disease beneficiaries are not eligible unless they already were HMO enrollees at the time they were certified as Medicare-eligible due to end-stage renal disease.

[2] All the analyses in this chapter use mid-1995 counts of total beneficiaries and enrollees in risk-contracting plans.

rates across the country. This section begins with a brief description of the current payment method. It then summarizes the method's shortcomings and their effect on plan participation and Medicare costs.

The AAPCC-Based Capitation Payment Method

The Health Care Financing Administration (HCFA) establishes Medicare capitation payment rates each year that are based on an estimate of local fee-for-service adjusted average per capita costs.[3] These per capita costs reflect direct fees paid by Medicare for health care services, the volume and intensity of services rendered, and any other special payments made to providers in the Medicare fee-for-service sector. The AAPCCs are calculated annually using the following methodology:

- National average monthly per capita costs (USPCCs) are projected for the coming year by updating historical data on Medicare expenditures and estimating expenditures for new payment policies not reflected in the data.

- County-level AAPCCs are calculated by adjusting the USPCCs by five-year average ratios of county to national per capita fee-for-service expenditures.

Monthly capitation rates are established for each county at 95 percent of the AAPCCs.

An HMO's capitation rate for each month is risk adjusted for the expected costs of care of the HMO's current enrollee mix. HCFA has defined risk classes based on disability, age, sex, Medicaid status, institutional status, and employment status.[4] The adjusters are ratios of the national average per capita costs for each risk class to the overall national average.

Each year, a Medicare risk-contracting plan is required to compare its expected Medicare revenue for the coming year with an estimate of what it would receive for its Medicare enrollees under its commercial rates, after adjusting those rates for differences in benefits packages and service use between the commercial and Medicare populations. This estimate, called the adjusted community rate (ACR), is used to recapture any excess savings that plans gain under the AAPCC rates. If a plan's expected Medicare revenue is estimated to exceed its ACR, the plan must return the surplus to Medicare or spend it by providing additional supplemental benefits to Medicare enrollees. In practice, virtually all plans return any surplus to enrollees in the form of richer benefits.

Issues with the Risk Program AAPCC Payments

Several key issues with the current AAPCC-based payment methodology merit attention. Payment rates vary widely across the country. Risk plans also have been paid for fee-for-service medical education and

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[3] Separate sets of Part A and Part B capitation rates are established for elderly beneficiaries, those who are Medicare-eligible because of disability, and end-stage renal disease beneficiaries.

[4] The risk factor for employment status was used for the first time in 1995 to adjust for differences in Medicare per capita costs for beneficiaries who are employed and have other insurance coverage in addition to Medicare.

disproportionate share hospital (DSH) payments that they may not actually have incurred.[5] Finally, the payment method restricts the ability of the Medicare program to recapture cost savings achieved by participating plans. Inadequacy of current risk-adjustment methods, as discussed in Chapter 15, also has been a problem for the Medicare risk program.

Variation and Volatility of Payment Rates. Variation in counties' AAPCC rates reflect local differences in both provider input prices (for example, costs of wages or supplies) and per capita service use patterns (volume and intensity) in the Medicare fee-for-service sector, as well as differences in other components of Medicare fee-for-service payment policy. By comparison, rates may be calculated that adjust a national average rate only for variation in input prices across counties, called input-price-adjusted rates.[6] The much larger variation in the AAPCC rates across the country, compared with input-price-adjusted rates, reflects large differences in service use patterns. The 1995 AAPCC rates ranged from a low of $177 per month to a high of $679, while the input-price-adjusted rates ranged only from $324 to $530. On average, the AAPCC rates are higher for urban counties and lower for rural locations than the input-price-adjusted rates. They also vary more than the input-price-adjusted rates within each geographic grouping, as shown by larger standard deviations (Table 5-1).

Fluctuations in service use patterns over time create volatility in a county's AAPCC rates, and these fluctuations tend to be larger for areas with small Medicare populations. Health plans serving counties with volatile rates face greater uncertainty regarding payment rates for future years. The average volatility of payment rates is about 50 percent greater for rural than for urban counties (Table 5-1). Volatility exceeds 20 percent for some rural counties.

Both the levels of AAPCC-based payment rates and their volatility over time have influenced Medicare risk-plan enrollment rates. The Commission's analysis indicates that, in urban counties, the level of payments is one of the important factors influencing enrollment rates, with higher enrollment rates where payment rates are high. Payment volatility appears to have a weaker but measurable effect, with lower enrollment rates where volatility is high (PPRC 1995).[7]

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[5] A related issue that has been examined by the Prospective Payment Assessment Commission is Medicare costs for veterans. Their Medicare costs are lower than average because some of their health care benefits are covered by the Department of Veterans Affairs, which decreases the per capita costs used to establish the AAPCCs.

[6] Measurement issues involved in developing input price indexes for capitated health plans are discussed later in the chapter. For this analysis, an input-price-adjusted national average rate for each county was obtained by multiplying the national average Part A and Part B AAPCC rates by input price factors and summing the resulting rates. Medicare Fee Schedule geographic adjustment factors for 1996 were applied to 66 percent of the Part B rate, and the 1996 Medicare hospital wage indices were applied to 70 percent of the rest of the Part B rate and to 70 percent of the Part A rate. This wage index formula assumes that costs of wages for other services provided by institutional providers are similar to those of hospital inpatient services, that is, these providers compete in the same labor markets and labor costs are 70 percent of their total costs. The remaining 30 percent constitutes costs of supplies and equipment that are sold and priced consistently in a national market.

[7] Because a mix of other factors (for example, overall managed-care market penetration or the socioeconomic profile of a market) also affect local risk-plan enrollment rates, it is difficult to separate out the role of each factor and estimate how sensitive enrollment rates might be to changes in payment rates. In addition, this analysis provided evidence of payment effects for urban areas, but not for rural ones. Additional work remains to be done to obtain accurate measurement of these relationships.

Table 5-1. Average Medicare Risk-Plan Payment Rates, Payment Volatility, and Enrollment Rates, by Urban and Rural Location, 1995

	AAPCC Rate (standard deviation)	Input-Price-Adjusted Rate (standard deviation)	Payment Volatility*	Enrollment Rate
All Counties	$402 (92)	$402 (46)	2.2%	7.3%
Urban Counties	428 (87)	418 (42)	2.1	9.4
Central urban	499 (83)	441 (40)	1.8	16.8
Other urban	393 (64)	406 (37)	2.2	5.8
Rural Counties	323 (50)	357 (20)	2.9	0.6
Urban fringe	330 (51)	357 (18)	2.7	0.7
Other rural	317 (48)	354 (21)	3.1	0.5

SOURCE: Physician Payment Review Commission analysis of Medicare AAPCC payment rates for 1991 through 1995 and risk-plan eligibility and enrollment data from the group health plan master file for mid-1995.

* Payment volatility is measured as the annual average magnitude of change (higher or lower) in a county's payment index for 1991 through 1995 as a percentage of its five-year average index for that time period. The payment index is the ratio of the county's AAPCC rate to the national average rate per beneficiary.

Relationships between payment and enrollment rates differ by urban or rural location. Overall average enrollment rates were 0.6 percent for counties that had payment rates lower than $300 in 1995, and they ranged upward to 15.2 percent for counties with rates of $500 or higher (Table 5-2). By location, however, enrollment rates were consistently high in central urban counties, and consistently low in the most rural counties, regardless of payment rates. Only smaller (noncentral) urban counties and rural counties adjacent to urban areas had higher enrollment rates where payment rates were higher.

Medical Education and Disproportionate Share Payments. Medicare fee-for-service payments for inpatient hospital stays include payments for direct and indirect medical education costs incurred by teaching hospitals and extra payments to hospitals that serve a disproportionate share of low income beneficiaries. These payments are retained in the expenditures used to calculate the AAPCCs. As a result, an AAPCC reflects a county's average monthly per capita cost for fee-for-service medical education and DSH. These amounts may not correspond with actual risk-plan costs, however, because not all plans have medical education programs or use teaching or disproportionate share hospitals.

Medical education and DSH payments are an estimated 5.5 percent of the AAPCC rates overall, but their share of total payment rates varies across the country (Table 5-3). On average, medical education and DSH payments represent only 3.6 percent of capitation rates for rural counties but 6.1 percent of the rates for urban ones. They average 8.4 percent of payment rates for the most densely populated, central urban counties. These estimates represent the size of reductions that would occur if medical education and DSH payments were removed from the Medicare capitation rates.

Medicare beneficiaries, in particular those who are risk-plan enrollees, tend to live in counties where medical education and DSH payments are larger shares of the payment rates. More than 30 percent of risk-

Table 5-2. Average Medicare Risk-Plan Enrollment Rates, by Level of Payment and Urban/Rural Location, 1995

	Payment Levels			
	<$300	$300-399	$400-499	$500+
Percentage Enrollment				
Central urban	-	15.3%	16.9%	16.9%
Other urban	1.5%	4.4	7.2	11.0
Rural-urban fringe	0.4	0.8	0.9	3.2
Other rural	0.1	0.7	0.3	0.1
Total	0.6	3.9	10.5	15.2
Number of Counties				
Central urban	0	8	31	15
Other urban	90	478	197	25
Rural-urban fringe	259	501	68	4
Other rural	652	727	86	2
Total	1,001	1,714	382	46

SOURCE: Physician Payment Review Commission analysis of Medicare AAPCC payment rates for 1995 and risk-plan eligibility and enrollment data from the group health plan master file for mid-1995.

Table 5-3. Estimated Medical Education and Disproportionate Share Payments as Components of Medicare Risk-Plan Payment Rates, by Urban and Rural Location, 1995 (percentage)

	Medical Education	Disproportionate Share	Total Percentage
All Counties	3.4%	2.1%	5.5%
Urban Counties	3.8	2.3	6.1
Central urban	5.3	3.1	8.4
Other urban	3.1	1.9	5.0
Rural Counties	2.1	1.5	3.6
Urban fringe	2.2	1.6	3.8
Other rural	1.9	1.5	3.4

SOURCE: Physician Payment Review Commission analysis of Medicare Part A expenditures for the 5 percent sample of beneficiaries for 1993, published AAPCC rates for 1995, and risk-plan eligibility and enrollment data from the group health plan master file for mid-1995.

plan enrollees are in counties with medical education and DSH shares of 7 percent or greater, and another 37 percent are in counties with 4 percent to 6 percent shares (Table 5-4).

Medicare Savings. By design, the only savings for Medicare from the risk program is the 5 percent reduction in per capita costs obtained by setting payments at 95 percent of the AAPCCs. The payment method has no other mechanism for Medicare to recapture actual cost savings achieved by plans. The ACR

Table 5-4. Estimated Medical Education and Disproportionate Share (DSH) Payments for Counties, Beneficiaries, and Plan Enrollees, 1995 (percentage)

Medical Education/DSH Share of Capitation Rate	Counties	Beneficiaries	Risk-Plan Enrollees
0 percent	7.8%	1.1%	0.1%
1-3 percent	48.4	33.3	29.4
4-6 percent	30.2	34.1	36.6
7-9 percent	9.4	19.2	24.2
10 percent or more	4.2	12.3	9.7

SOURCE: Physician Payment Review Commission analysis of Medicare Part A expenditures for the 5 percent sample of beneficiaries for 1993, published AAPCC rates for 1995, and risk-plan eligibility and enrollment data from the group health plan master file for mid-1995.

mechanism is intended to recapture savings by plans, but any savings are shared with enrolled beneficiaries rather than with Medicare. In addition, because the ACR adjustment is difficult to calculate accurately, the reported ACRs cannot be interpreted with much confidence as reflecting plan costs.

DESIGNING A CAPITATION PAYMENT METHOD

Proposals to improve the Medicare risk program or broaden private-plan options share two purposes. The first is to increase beneficiaries' choice of health plans. The second is to control the growth of Medicare spending. The design of the capitation payments has a critical role in accomplishing these purposes.

Key decisions involved in designing any capitation payment method include how to define the payment areas for which capitation rates are established and how to set and update payment rates for those areas. In the current Medicare risk program, for example, counties are the payment areas, Medicare fee-for-service per capita costs are the basis for the payment rates, and new payment rates are calculated each year using the most recent information on Medicare fee-for-service spending.

The recent proposals for broadening health-plan choices would continue to use an administered pricing system that sets capitation rates based on a formula. All forms of participating plans would be paid the established capitation rates. One proposed approach would use the AAPCC rates for a specified year as the baseline capitation rates, and then would obtain rates for each succeeding year by applying a uniform update to the previous year's rates. Another approach would use the existing AAPCC payment method with some modifications. Current problems with the AAPCC rates would affect any payment system that relied upon them.

An alternative approach would be to use competitive bidding, which is a market-based method that emphasizes establishing capitation rates that reflect the expected cost per enrollee for efficient health plans within each market. Competitive bidding is used extensively in private health care markets, and its use has been growing in the public sector. A competitive bidding process would create a mechanism for health plans to compete on price. Two elements that are essential to encourage plans to bid close to their

economic costs are strong competition among multiple bidders and a penalty for those that bid too high (Christianson and Smith 1984; McCombs and Christianson 1987).

Last year, the Commission suggested introduction of competitive bidding in the Medicare risk program (PPRC 1995). Although current legislative proposals do not use competitive bidding, it should continue to be evaluated as a payment option. Competitive bidding could correct many of the problems with AAPCC rates by uncoupling Medicare capitation rates from Medicare fee-for-service expenditures, and it could allow Medicare to share cost savings achieved by capitated plans. There is a risk, however, that competitive bidding might place health plans at a competitive disadvantage with the traditional fee-for-service program, unless beneficiaries' premiums for that program also were based on competitively bid Medicare payment rates. It also would be effective only in those Medicare markets that had adequate numbers of health plans bidding to achieve strong price competition.

This section discusses several of the elements involved in designing a new Medicare capitation payment system based on the AAPCC rates. It first examines alternative techniques to address problems with the AAPCC method. Then it describes factors to be considered in determining the annual updates for payment rates. Finally, it discusses how payment modifications could affect Medicare costs and identifies options for implementing changes in a budget-neutral manner.

Correcting Problems with the AAPCC-Based Rates

Several options have been considered for modifying the AAPCC rates. These approaches would be relevant both for Medicare capitation rates that continued to be based on the AAPCCs and for a payment system that used the AAPCC rates only to establish baseline capitation rates.

Reducing Geographic Variation in Rates. Policies to reduce geographic variation in the input price and service use components of the AAPCC rates involve separate issues.[8] It is generally accepted that geographic adjustments should recognize input price factors that health plans cannot control, such as local wage rates or supply costs. It is less clear how much of the geographic variation in service use patterns is acceptable, and individual determinants of service use are not currently measurable with any degree of confidence. Examples of these determinants include the health and socioeconomic status of beneficiaries, health care preferences, and physician practice styles.

In the absence of complete information on sources of service use variation, analytical methods may be used to reduce the range of AAPCC rates. Three types of methods have been considered, to be used either alone or in combination: blended rates, trimming, and differential updates.

All of these techniques, as discussed below, rely on input price indexes to allow capitation rates to reflect local differences in prices faced by health plans. To establish an input price index for a payment area, individual indexes would be developed for different categories of services, measuring the input prices faced by health plans in local payment areas relative to national average input prices. These indexes would

[8] See Chapter 14 for further discussion of this issue.

be applied to a national average mix of services to obtain an overall input price index for each payment area. Measurement issues to be addressed in developing these indexes include how to group services into categories, how to measure the prices of health-plan inputs for each category, and how to account for variations in service mix for different types of plans when establishing the national service mix. For example, the service mix for HMOs may be more heavily weighted toward outpatient services than that for fee-for-service plans.

Blended Rates. A blended rate is a weighted average of a payment area's AAPCC rate and input-price-adjusted national average rate. By blending the AAPCC and input-price-adjusted rates, some portion of service use variation would be retained in the rates for all payment areas. The amount of variation retained would depend on the weights placed on the AAPCC rates. For example, a blend based 90 percent on the local rate and 10 percent on the input-price-adjusted rate would retain more local service use variation than a 60/40 percent blend.

Trimming. This method defines upper and lower payment thresholds and trims payment rates that exceed those thresholds by setting them at, or closer to, the thresholds. The thresholds sometimes are called floors and ceilings. It is theoretically preferable to adjust the thresholds for local differences in input prices before trimming, to avoid penalizing health plans in areas with high input prices or overpaying those in areas with low input prices. Trimming differs from blended rates by accepting service use patterns for all payment areas except those that exceed the thresholds.

The number of payment areas affected by trimming would depend on the way the thresholds were defined, how close to the national average capitation rate they were set, and the year in which they were implemented. Thresholds might be defined as a percentage of the average rate or as a fixed dollar amount. In any given year, thresholds set closer to the national average rate would affect a larger number of counties. Thresholds defined in nominal terms would affect different numbers of counties over time because payment rates would be higher in future years. For example, a fixed $300 floor would affect fewer counties in later years, whereas a fixed $500 ceiling would affect more counties.

Differential Updates. A differential update method compares an area's payment rate for the current year to specified payment thresholds to determine how much its payment rate will be increased for the following year. This method may be viewed as a form of trimming. For example, a payment rate that was lower than 80 percent of the national average rate might get an annual update that was larger than average, and a rate that exceeded 120 percent of the average would get a smaller-than-average update. Preferably, thresholds would be adjusted for local differences in input prices, to avoid penalizing plans serving areas with high input prices. Differential updates would ensure that all payment areas had at least some increase in payment rates from one year to the next, which might not be true for blended rates or trimming methods.

Combining Methods. Payment floors or ceilings could be used in combination with either blended rates or differential updates to achieve a larger increase in low rates or decrease in high rates. The effect of the combination of methods on payment rates would differ depending on whether the thresholds were applied before or after the rates were blended. If the blended rates were set first, the blending would change some

number of the very high or low rates so that they no longer exceeded the thresholds. Then any remaining blended rates in excess of the thresholds would be raised or lowered. If a floor (or ceiling) were applied first, there would be a greater total increase (or reduction) from the original payment rates, because the threshold would become the local area rate used to obtain blended rates.

Reducing Payment Volatility. The choice of the sizes of Medicare population bases for calculating AAPCC capitation rates involves a tradeoff between controlling payment volatility and achieving capitation rates that accurately represent the expected costs of health care for any particular enrollee. Capitation rates for payment areas with smaller populations are expected to be more accurate for any given enrollee than those for larger, more diverse populations. Rates calculated for small populations, however, fluctuate more over time. Any payment method that calculated new AAPCCs each year would continue to face this tradeoff.

Last year the Commission suggested use of either larger payment areas or a statistical technique called the shrinkage estimator to reduce the volatility of AAPCC rates (PPRC 1995).[9] Previous research has shown that using larger, multicounty areas based on urban cores, urban rings, and rural areas would reduce AAPCC volatility (Welch 1989; Rossiter and Adamache 1990; Porell et al. 1990; Welch 1991). Although many designs are possible, the one identified most frequently in legislative proposals is to define each metropolitan statistical area (MSA) as a payment area, and to define one rural area for each state that includes all non-MSA counties.

A payment method that used the AAPCC rates for a given year as its baseline, but not for succeeding years, would eliminate this source of payment volatility. Because using one year's AAPCC rates would freeze fluctuating rates at just one point in time, however, some have suggested using multiyear average rates to represent local rates more accurately for the baseline.

Removal of Medical Education and DSH Payments. The purpose of removing medical education and DSH payments from the capitation rates would be to ensure that these payments were made to providers or health plans that actually incurred such costs. If a payment method continued to calculate AAPCC rates each year, these payments could be excluded from the fee-for-service expenditures used in the calculations. For a payment method that used AAPCC rates only for its baseline, medical education and DSH payments could be removed from the baseline rates.

As the Commission recommended last year, a better way to pay for medical education and DSH costs would be to establish a general funding method where Medicare would pay directly for these costs, independent of the capitation rates (PPRC 1995). Hospitals would receive a direct medical education and DSH payment for each plan enrollee they served, and health plans with teaching programs would receive medical education payments. Any method that uncoupled rates from Medicare fee-for-service costs and

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[9] A shrinkage estimator is a weighted average of a county's rate and the rate for a larger geographic area that contains the county. The weight applied to a county rate would be smaller for a rate with high variance and larger for one with low variance (Newhouse 1986). This method would reduce the volatility of county-level AAPCC rates while retaining some of the population homogencity.

reduced geographic variation in payment rates would implicitly remove some or all of Medical education and DSH payments from currently high capitation rates. A separate funding mechanism might be appropriate in such a case, even if the capitation method did not actually define the changes as removal of medical education and DSH payments.

Annual Updates for Capitation Rates

Annual updates of Medicare capitation rates could be established in different ways, depending on what was intended to be achieved. The current system, which calculates AAPCC rates each year, retains growth in each payment area's capitation rate that is comparable to the increase in its Medicare fee-for-service per capita costs. For an alternative system that applied uniform updates to a previous year's capitation rates, the choice of update factor may place different priorities on such elements as price inflation or costs of new health care technology.

Several approaches have been suggested for establishing uniform annual updates. Updates that were specified explicitly in legislation, for example, would emphasize control of the growth in costs for capitated plans. Fixed nominal updates would offer certainty about future Medicare costs, but they would not be responsive to any unexpected changes in inflation or health care technology in future years. Updates that were fixed in real dollars (say inflation plus 2 percent) would allow updates to reflect changes in inflation. Updates might be based on the growth in nominal per capita gross domestic product, which would adjust payments for both price inflation and rates of increase in per capita goods and services in the U.S. economy. Basing updates on the growth in private health insurance per capita payments would allow Medicare capitation payments to rise at rates comparable to those of the private market. This last method, however, would require adjustments to private insurance spending for differences in benefit packages and service use intensity, which raises difficult measurement problems.

In a transition period when corrections to baseline capitation rates were being implemented, the net updates for payment areas' capitation rates would be the combined result of the annual payment updates and the baseline corrections. Some payment areas with high capitation rates relative to their input-price-adjusted rates could have extremely small or negative net updates in nominal dollars. (In real dollars, many more of these areas would experience rate reductions.) One way to mitigate negative effects for existing health plans would be to phase in corrections to the baseline rates over several years. A provision for a specified minimum update also might be adopted, which could be used alone or in combination with a phased-in correction method.

Payment Changes and Budget Neutrality

Alternative mechanisms to reduce the geographic variation in the baseline rates would have differing effects on individual payment areas, and therefore on Medicare spending. Blended rates and differential updates would compress the range of rates relatively evenly across areas, moving all rates closer to the national average. Payment floors would raise only the lowest rates, and ceilings would reduce only the highest ones.

The net effect of payment corrections on Medicare spending would depend on how payment rates changed in payment areas where enrollees live. Current risk-plan enrollees tend to live in areas with higher

payment rates. In 1995, the national average AAPCC rate was $402 per beneficiary, but Medicare paid risk plans an average of $465 per risk-plan enrollee. Therefore, the initial net effect of payment corrections would be to lower Medicare spending, as reduction in the higher rates decreased spending more than raising lower rates increased it. To the extent that enrollment patterns shifted over time in response to payment rate changes to reflect more closely the geographic distribution of all Medicare beneficiaries, the net change in Medicare spending would move toward zero.

Policymakers could choose to retain any savings achieved by a payment correction method, or they might wish to maintain budget neutrality with what Medicare spending per health-plan enrollee would have been without any correction. The method used to maintain budget neutrality would depend on the nature of the changes made to the capitation rates. For blended rates or differential updates, for example, a uniform budget neutrality adjustment factor could be applied to capitation rates for all payment areas. By contrast, the additional costs created by either a payment floor or minimum update might be financed by reducing payment rates for payment areas that are not eligible for these provisions.

CAPITATION METHODS IN MEDICARE RESTRUCTURING PROPOSALS

This section summarizes the payment methods in the conference agreement and Daschle proposal, and it estimates the effects of each proposal on capitation rates. These legislative proposals would phase in moderate blended rate formulas and would establish a minimum update provision, both of which would protect counties with high rates from very low or negative updates. At the same time, the proposals have provisions for payment floors that would establish quite large increases for payment areas with payment rates that now are low.

The Conference Agreement

The conference agreement proposes a MedicarePlus option that would broaden the choice of private health plans for Medicare beneficiaries. MedicarePlus plans would be required to charge a uniform premium for all Medicare enrollees in each payment area. Medicare payments to plans for Medicare-covered benefits would be monthly capitation payments that are risk adjusted based on a plan's enrollee mix.[10] It also would continue current policies of the risk program that limit beneficiary premiums to the actuarial value of Medicare fee-for-service cost sharing and that require plans to return savings in excess of their ACRs through richer supplemental benefits or to Medicare.

The conference agreement would retain counties as the payment areas and would use the county-level AAPCC-based rates for 1995 as the baseline capitation rates.[11] It would introduce blended rates and

[10] The conference agreement excludes capitation rates for end-stage renal disease enrollees from its proposed payment method, and directs the Secretary of Health and Human Services to develop a separate, actuarially equivalent capitation payment method for this group.

[11] States would be permitted to request alternative payment area definitions, including statewide areas, regional areas based on MSAs and rural areas, or noncontiguous regional areas.

payment floors to reduce the geographic variation in payment rates. The proposal has no explicit provision to remove medical education or disproportionate share payments from capitation rates, although some of the same effect would be achieved by other mechanisms to reduce geographic variation in rates. It would establish a separate funding mechanism to make direct payments for medical education and DSH to hospitals serving plan enrollees and for medical education to health plans with teaching programs. Annual uniform updates would be applied to the baseline rates to obtain rates for 1996 and succeeding years, according to a proposed schedule of fixed percentage updates delineated in the legislation. This design, by uncoupling capitation rates from Medicare fee-for-service expenditures, would eliminate the problem of payment volatility over time; it would control Medicare costs for health-plan enrollees through the update mechanism.

The proposed mechanism to reduce geographic variation in the payment rates contains the following components:

- Blended payment rates using local area rates and input-price-adjusted national average payment rates would be phased in over a six-year period. In 1996 and 1997, the blend would be based 90 percent on local rates and 10 percent on input-price-adjusted rates. Blending would be phased in by 5 percentage point increments each year, reaching a 70/30 percent blend in 2001.

- The blended rates would be adjusted each year so that total Medicare expenditures for plan enrollees were equal to what they would have been if local payment rates, with uniform updates, were used for all payment areas.

- Minimum monthly payment rates would be established at $300 in 1996 and $350 in 1997. The $350 minimum would be updated in succeeding years along with the payment rates. After blending, any payment rate lower than the floor would be raised to the floor.

- A minimum 2 percent update would be established. After blending, any payment rate that was less than 2 percent higher than the previous year's rate would be raised to attain the minimum update.

- The payment floors and minimum updates would be financed by reducing the payment rates for all remaining counties to maintain budget neutrality.

Capitation payment provisions in the House and Senate Medicare bills, from which the payment method in the conference agreement was drawn, shared many features including the 1995 payment rate baseline and uniform annual updates. Other provisions differed markedly. The House bill defined counties as the payment areas, and the Senate bill used multicounty regions. The Senate bill proposed removal of medical education and DSH payments from payment rates, phasing them out over two years. The bills also differed in the method used to reduce the geographic variation in capitation rates, and how much of the variation they would reduce. The Senate bill proposed the blended rate method that was adopted for the conference agreement, but its proposed 50/50 percent blend would reduce variation in rates more than the 70/30

percent blend in the conference agreement. The House bill proposed a differential update mechanism, together with payment floors, to achieve a more moderate reduction in payment variation.

Estimated Effects on Payment Rates. Capitation rates under the payment method proposed in the conference agreement were simulated for 1996 through 2001 to analyze effects on the levels of payments across the country, and to identify any unforeseen policy implications of the payment design.[12] The estimated payment rates are approximations of what rates would be if the conference agreement was adopted, based on currently available information. Estimates for future years are more uncertain than those for early years. Differences between these estimates and actual payment rates under a fully implemented policy will depend on how individual components are measured, as well as responses by health plans and beneficiaries to new Medicare policies.

These estimated payment rates are based on fixed enrollment counts as of mid-1995. They do not reflect any shifts in enrollment patterns over time in response to changes in payment rates since such shifts are extremely difficult to predict with any confidence. Changes in the distribution of enrollment would affect future payments through the budget-neutrality adjustments related to the blended rates, payment floors, and minimum updates. Preliminary analyses indicate that short-term shifts in enrollment patterns due to changes in payment rates are likely to be small, because the magnitude of adjustments to rates each year would be relatively small.

The simulations indicate that, over six years, the combination of blended rates and payment floors would reduce the range of payment rates substantially (Table 5-5). The standard deviation would decline from 23 percent to an estimated 18 percent of the mean, and the range would decline from 284 percent to 105 percent of the minimum. By comparison, the input-price-adjusted rates (in which the only source of variation is input prices) have a standard deviation that is 10 percent of the mean and a range that is 55 percent of the minimum.

The payment floors would make a strong contribution to reducing variation in payment rates by increasing the lowest rates. Establishing the $300 floor in 1996 would increase payment rates for an estimated 404 counties—in some cases substantially—and raising the floor to $350 in 1997 would lead to higher rates for 1,120 counties (Table 5-6). The number of counties affected would decrease in each succeeding year as the blended rates were phased in through 2001. Because these fixed level payment floors would not be adjusted for local differences in input prices, however, they would overpay plans serving some counties with low input prices.

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[12] The simulation used the 1995 AAPCC rate for each county as the baseline local area rate. The baseline 1995 input-price-adjusted rate was estimated using the formula specified in Section 1854(c)(4)(C) of the bill entitled "Special Rules for 1996." For 1996 through 2001, each county's local area and input-price-adjusted rates for the previous year were increased by the specified update, and its blended rate was calculated using the blending percentages specified for each year. The blended rates were adjusted to achieve budget neutrality with what expenditures would have been without the blending, based on mid-1995 standardized risk-plan enrollment in each county. Payment rates then were increased for counties that qualified for a payment floor or minimum update, and rates for all other counties were decreased to finance these costs, using an iterative process to prevent other counties from falling below the payment floor or minimum update.

Under the proposed schedule for phasing in the blended rates, it does not appear that the 2 percent minimum update provision would be triggered. For these payment estimates, it was applicable for only one county in the year 2000. The minimum update could have an effect, however, if any of the payment

Table 5-5. Estimated Effects of the Proposed MedicarePlus Capitation Payment Method on the Variation in Monthly Payment Rates, 1996-2001 (nominal dollars)

	1995 AAPCC Rate	1996 90/10 Blend ($300 floor)	1997 90/10 Blend ($350 floor)	1998 85/15 Blend*	1999 80/20 Blend*	2000 75/25 Blend*	2001 70/30 Blend*
National Rate							
Mean	$402	$438	$457	$479	$500	$520	$550
Standard deviation	92	92	92	94	95	97	99
Percentage of average	23%	21%	20%	20%	19%	19%	18%
Distribution of Rates							
Minimum	$177	$300	$350	$366	$382	$396	$418
Median	325	356	370	390	410	429	456
Maximum	679	719	746	773	798	820	856
Range	502	419	396	407	416	423	438
Percentage of minimum	284%	140%	113%	111%	109%	107%	105%

SOURCE: Physician Payment Review Commission analysis of Medicare AAPCC payment rates for 1991 through 1995 and risk-plan enrollment data from the group health plan master file for mid-1995.

* The $350 floor initiated in 1997 would be increased each year by the applicable annual update.

NOTE: These estimates are based on the most recent data for 1996 input price factors and metropolitan statistical area definitions. They therefore differ slightly from the estimates released in late 1995.

Table 5-6. Effect of Payment Floors in the Proposed MedicarePlus Payment Method, 1996-2001

Payment Floor Applicable	1996 90/10 Blend ($300 floor)	1997 90/10 Blend ($350 floor)	1998 85/15 Blend*	1999 80/20 Blend*	2000 75/25 Blend*	2001 70/30 Blend*
Number of Counties	404	1,120	1,037	944	847	736
Percentage of:						
Counties	12.9%	35.6%	33.0%	30.0%	26.9%	23.4%
Beneficiaries	3.2	12.3	11.3	9.6	8.0	6.8
Risk-plan enrollees	<0.1	0.8	0.7	0.4	0.3	0.2

SOURCE: Physician Payment Review Commission analysis of Medicare AAPCC payment rates for 1991 through 1995 and risk-plan enrollment data from the group health plan master file for mid-1995.

* The $350 floor initiated in 1997 would be increased each year by the applicable annual update.

NOTE: These estimates are based on the most recent data for 1996 input price factors and metropolitan statistical area definitions. They therefore differ slightly from the estimates released in late 1995.

method provisions were changed. As discussed below, for example, estimates indicate that this provision would be triggered if the baseline year was 1996 instead of 1995.

Average payment rates for both rural and urban areas would move closer to the national average rate as a result of the blended rates and payment floors (Table 5-7). Estimates show that ratios of average local rates to the national average would move from 0.82 to 0.85 for rural counties adjacent to urban areas, and from 0.79 to 0.83 for other rural counties. For the central urban counties, the ratio would move from 1.24 to 1.19. For comparison, the ratios of the average input-price-adjusted rates to the national average are 1.09 for central urban counties, 1.01 for other urban counties, 0.90 for rural counties on the fringe of urban areas, and 0.89 for other rural counties.

The use of blended rates, payment floors, and minimum updates, combined with uniform annual updates, would cause counties to have differing rates of net increase in their payment rates through 2001 (Table 5-8). Actual updates would become uniform across all counties after 2001 when the phase-in of blended rates was completed. The introduction of payment floors in 1996 and 1997 would create broader ranges of updates in those years than in later years. Because both the 90/10 blend and the $300 floor would be introduced in 1996, updates from 1995 to 1996 are estimated to vary widely. The uneven distribution of estimated updates in 1997 is the combined effect of retaining the 90/10 percent blend for two years while

Table 5-7. Average Monthly Payment Rates per Beneficiary under the Proposed MedicarePlus Payment Method, by Urban and Rural Locations, Selected Years (nominal dollars)

	1995 AAPCC Rate	1996 90/10 Blend ($300 floor)	1997 90/10 Blend ($350 floor)	2001 70/30 Blend*
All Counties	$402	$438	$457	$550
Urban Counties	428	464	483	580
Central urban	499	536	556	657
Other urban	393	428	446	541
Rural Counties	323	356	379	459
Urban fringe	330	363	384	465
Other rural	317	351	375	454
Ratio to National Average				
Central urban	1.24	1.22	1.22	1.19
Other urban	0.98	0.98	0.98	0.98
Rural-urban fringe	0.82	0.83	0.84	0.85
Other rural	0.79	0.80	0.82	0.83

SOURCE: Physician Payment Review Commission analysis of published Medicare AAPCC payment rates and risk factors for 1995, data on 1995 enrollment for beneficiaries and risk-plan enrollees, and the 1995 AAPCC master file.

* The $350 floor initiated in 1997 would be increased each year by the applicable annual update.

NOTE: These estimates are based on the most recent data for 1996 input price factors and metropolitan statistical area definitions. They therefore differ slightly from the estimates released in late 1995.

Table 5-8. Distribution of Beneficiaries by Rate of Annual Update under the Proposed MedicarePlus Payment Method, Selected Years (percentage)

Level of Update	1996 90/10 Blend ($300 floor)	1997 90/10 Blend ($350 floor)	2001 70/30 Blend*
> 10 Percent	20.4%	6.5%	-
10 Percent	17.0	0.8	-
9 Percent	18.0	0.6	<0.1%
8 Percent	21.7	1.2	0.9
7 Percent	15.2	1.1	19.1
6 Percent	5.9	0.7	47.6
5 Percent	1.8	1.0	29.0
4 Percent	<0.1	88.1	3.4
3 Percent	-	-	<0.1

SOURCE: Physician Payment Review Commission analysis of published Medicare AAPCC payment rates and risk factors for 1995, data on 1995 enrollment for beneficiaries and risk-plan enrollees, and the 1995 AAPCC master file.

* The $350 floor initiated in 1997 would be increased each year by the applicable annual update.

NOTE: These estimates are based on the most recent data for 1996 input price factors and metropolitan statistical area definitions. They therefore differ slightly from the estimates released in late 1995.

increasing the floor from $300 to $350. More than 88 percent of beneficiaries are in counties that would get 3.8 percent updates. The rest are in counties that would be subject to the floors, many of them getting a 17 percent update when they moved from a $300 monthly rate to $350.

Choice of Baseline Year. Estimates show that changing to a 1996 baseline would have a small impact on overall payment rates. Although the conference agreement specifies the 1995 AAPCC rates as the baseline rates, Medicare started using the 1996 AAPCCs to pay risk plans in January 1996. The average AAPCC rate per beneficiary rose 10 percent from 1995 to 1996, but the average rate per risk-plan enrollee grew only 8.1 percent because the AAPCC rates for counties where enrollees lived went up less than average. This increase is close to the 8 percent update for 1996 proposed in the conference agreement. Estimates of payments for a 1996 baseline indicate that a 1997 update of 3.65 percent, instead of the proposed 3.8 percent, would achieve the conference agreement's budgeted level of per enrollee spending in 1997.

Effects of this new baseline would differ for individual counties. Only an estimated 911 counties would have payment rates lower than the $350 floor in 1997, compared with 1,120 counties for estimates using the 1995 baseline. In addition, an estimated 142 counties would be eligible for the 2 percent minimum update in 1997, compared with none for the original baseline.

The Daschle Proposal

The proposal developed by Senator Daschle has been supported by the Administration as an acceptable alternative to its own original proposal. The original proposal would have retained a modified form of the

existing AAPCC payment method as the capitation method for all Medicare managed-care options.[13] The Daschle proposal would use essentially the same payment method specified in the conference agreement. It diverges from the conference agreement in the following ways:

- The annual updates in the payment rates would be determined by the Secretary of Health and Human Services based on an estimate of the growth rate in private health insurance expenditures, adjusted to reflect differences in benefit package and service use intensity for Medicare beneficiaries. A default update of 7 percent would be used unless the Secretary determined otherwise.

- Medical education and DSH payments would be removed from the capitation rates beginning in 1997.

- The payment floors would be $310 in 1996 and $325 in 1997.

- There would be no provision for states to request alternative payment area definitions to replace counties.

Estimated Effects on Payment Rates. Estimated capitation rates under the Daschle proposal were simulated using the assumption that rates would be increased each year by the default 7 percent update. Because the blending method and payment floors are similar to those in the conference agreement, they would have similar effects on payments. A higher floor in 1996 would affect more counties, and the lower floor for 1997 would affect fewer ones. The cumulative effect of larger updates through 2001 would yield higher payment rates under this proposal than under the conference agreement.

Simulations suggest that it would not be possible to attain budget neutrality for health-plan enrollees in 1997 if both the provision to remove medical education and DSH payments and the 2 percent minimum update were implemented. As discussed above, counties with large shares of medical education and DSH in their capitation rates also tend to have larger risk-plan enrollments. A 7 percent update in payment rates could not offset large rate reductions sufficiently to reach a net 2 percent minimum update. As a result, an estimated 757 counties with more than 59 percent of current risk-plan enrollees would be eligible for the minimum update in 1997. Current enrollments in the remaining counties would be too small to be able to finance the cost of these minimum updates, and the dramatic growth in enrollment required to do so is unlikely to occur.

The financial consequences of removing medical education and DSH payments from capitation rates might be managed in several ways. These payments could be phased out over two or more years to mitigate the effect on updates for any single year. Alternatively, the Medicare program could pay the extra costs required to achieve the 2 percent minimum updates. Preliminary estimates indicate that this would

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[13] Two modifications to the AAPCCs were proposed by the Administration. One was a payment ceiling and floor for the Part B AAPCC rates at 80 percent and 150 percent of the national average rate, respectively, beginning in 1996. Medicare would pay a portion of the amount in excess of the ceiling on a decreasing schedule, so that by 2000 it only would pay up to the ceiling. Beginning in 1998, medical education and DSH payments would be excluded from the AAPCCs.

cost approximately $370 million, of which about $270 million would be incurred in 1997. Another option would be to define the minimum update relative to a 1996 payment rate that also removed medical education and DSH payments, thus excluding these payments from the minimum update requirement.

The effects of the Daschle proposal on the distribution of payments and payment floors were estimated based on the option to exclude medical education and DSH payments from the minimum update provision. The Daschle proposal would reduce the geographic variation in payment rates slightly more than the conference agreement by removing medical education and DSH payments (Table 5-9). Although this would yield lower average rates in 1997, larger annual updates are estimated to more than balance this effect over time. By 2001, payment rates would be higher, on average, than rates under the conference agreement.

Approximately 622 counties would be eligible for the $310 floor in 1996, and 749 counties would be eligible for the $325 floor in 1997 (Table 5-10). These figures compare with 404 counties for a $300 floor in 1996 and 1,120 counties for a $350 floor in 1997 estimated for the conference agreement.

MONITORING EFFECTS OF CHANGING THE CAPITATION PAYMENT METHOD

The effects of establishing a new capitation payment method should be monitored. This would be one component of an overall process to assess the effects of implementing new health-plan options for Medicare beneficiaries, which is described in Chapter 2. For a new payment method, the monitoring process should assess how well it achieved goals of encouraging plan participation and broader enrollment by beneficiaries across the country. It also should examine how new capitation rates may affect health plans, beneficiaries, and the Medicare program.

Table 5-9. Comparison of Estimated Capitation Payment Rates for the Conference Agreement and Daschle Proposals (nominal dollars)

	1995 AAPCC Rate	Conference Agreement 1997	Conference Agreement 2001	Daschle Proposal 1997	Daschle Proposal 2001
Average Payment Rate	$402	$457	$550	$438	$579
Standard Deviation as Percentage of Mean	23%	20%	18%	18%	17%
Range as Percentage of Minimum	284	113	105	107	96
Average Payment Rate by Location					
Urban Counties	$428	$483	$580	$460	$609
Central urban	499	556	657	519	677
Other urban	393	446	541	431	574
Rural Counties	323	379	459	367	488
Urban fringe	330	384	465	372	495
Other rural	317	375	454	363	483

SOURCE: Physician Payment Review Commission analysis of published Medicare AAPCC payment rates and risk factors for 1995, data on 1995 enrollment for beneficiaries and risk-plan enrollees, and the 1995 AAPCC master file.

Table 5-10. Effect of Payment Floors in the Daschle Proposal, 1996-2001

Payment Floor Applicable	1996 90/10 Blend ($310 floor)	1997 90/10 Blend ($325 floor)	1998 85/15 Blend*	1999 80/20 Blend*	2000 75/25 Blend*	2001 70/30 Blend*
Number of Counties	622	749	638	564	461	381
Percentage of:						
Counties	19.8%	23.9%	20.3%	17.9%	14.7%	12.1%
Beneficiaries	5.8	7.7	6.2	5.0	3.8	3.0
Risk plan enrollees	0.2	0.3	0.1	0.1	<0.1	<0.1

SOURCE: Physician Payment Review Commission analysis of published Medicare AAPCC payment rates and risk factors for 1995, data on 1995 enrollment for beneficiaries and risk-plan enrollees, and the 1995 AAPCC master file.

* The $325 floor initiated in 1997 would be increased each year by the applicable annual update.

Provisions in recent legislative proposals to correct deficiencies of the baseline AAPCC rates would affect the distribution of capitation rates across the country, and proposed annual updates would affect the overall levels of payments over time. As health plans and beneficiaries within local markets responded to these changes, new patterns would be expected to occur in plan participation, benefit packages offered, and enrollment rates.

Monitoring of changes in capitation rates should focus on behavioral responses to the changes that were anticipated or that raised concerns as the payment method was developed. For example, many policymakers have been reluctant to make large reductions in currently high payment rates for fear that lowering rates could lead to disenrollment from existing health plans, if plans increased cost sharing or reduced supplemental benefits in response to decreased revenues. Concern also has been expressed that higher rates in some areas could increase Medicare costs without achieving any improvements in access or quality of care. This could occur, for instance, if providers formed a fee-for-service plan to obtain the higher capitation rate but continued to deliver the same levels of care. In addition, many believe that raising currently low payment rates might not be sufficient to stimulate greater participation by managed-care plans in smaller markets.

This section begins with a discussion of expected responses to payment changes by health plans and beneficiaries. Then it identifies some measures of these responses that can be quantified and followed over time. Finally, it outlines some types of markets that should be examined as part of the monitoring process.

Expected Effects of Payment Changes

The introduction of new capitation rates for Medicare health plans would, to differing degrees, modify both the levels and volatility of capitation rates that now exist across the country. These changes would affect plans that currently have Medicare risk contracts, as well as any plans that are considering participation. As discussed above, when changes such as baseline corrections are introduced over time,

real payment rates may decrease for some payment areas from one year to the next, even though their nominal payment rates increase. This discussion refers to changes in real payment rates.

Changes in Levels of Payment Rates. The proposed blended rates and payment floors in recent legislative proposals would raise payment rates for some counties—particularly those with the lowest AAPCC rates—and decrease rates for others. The additional provision in the Daschle proposal to remove medical education and DSH payments from the capitation rates would reduce rates, and the magnitude of the reduction would differ across counties.

Counties where payment rates were increased would become more financially attractive to health plans, which could stimulate greater competition as more plans decided to enter those Medicare markets. As health plans' revenues went up, they likely would enrich the supplemental benefits they offered. They might do so to compete for enrollment or because their new payment rates exceeded their ACRs by greater amounts. Enrollment rates could increase as beneficiaries were offered greater choice of health plans and richer coverage for their out-of-pocket costs.

In other counties, reducing Medicare payment rates would decrease the revenues of health plans serving those counties. The prospect of lower profitability could stimulate a range of possible responses by the plans, depending on the amount of competition they faced and the size of their profit margins. Plans with many competitors might accept lower margins and continue operating as usual, particularly if they currently had large margins. Others might make changes in administrative functions, member services, or clinical services. Plans also might reduce the supplemental benefits offered or raise the premium they charged their Medicare enrollees. Some plans, for which rate reductions resulted in financial losses on their Medicare products, might discontinue their Medicare contracts. To the extent that plans left a market, the market would become less competitive.

Improved Predictability of Payment Rates. Payment changes that reduced fluctuation in Medicare payment rates would lessen uncertainty for all health plans regarding the levels of payments they would receive over time, thus decreasing their financial risk. The use of baseline rates and uniform updates by both the conference agreement and the Daschle proposal would eliminate payment rate fluctuation.

Reduction in payment volatility would have its strongest effect for counties with small beneficiary populations, many of which are rural areas. Such a change might encourage more health plans to participate in Medicare in these markets, particularly if it were combined with higher payment levels. It is not clear, however, how much competition among multiple plans might develop, because these small areas can support fewer health plans than larger, more densely populated markets.

Types of Changes to Monitor

Measures of the effects of payment method changes should be designed to allow the monitoring process to gather quantitative information on both immediate and long-term behavioral responses to these changes. The following groups of measures have been identified, each of which addresses behavioral responses or impacts for one of the market participants—health plans, beneficiaries, and the Medicare program.

Responses of health plans to new capitation rates may lead to changes in:

- the number and types of health plans participating in Medicare,
- the mix of supplemental benefits offered by participating plans,
- premiums that the plans charge beneficiaries, and
- the quantity and types of services provided by health plans.

Responses of Medicare beneficiaries to changes in the availability of health plans and the benefit packages, support services, and premiums or cost sharing they offered may lead to changes in:

- enrollment rates, overall and by type of plan,
- disenrollment rates, overall and by type of plan, and
- the geographic distribution of health-plan enrollees.

New payment rates, together with any related changes in enrollment patterns, will affect Medicare program costs in the form of the average payment amount per health-plan enrollee.

As discussed above, changes in payment rates might affect how much health plans spend to provide health care and support services for their enrollees, which could influence access to care, satisfaction with services, and quality of care. Although such factors are not listed here, they would be reflected in rates of health-plan enrollment and disenrollment. They also would be evaluated directly in any program to monitor quality or access to care for Medicare beneficiaries enrolled in managed care plans. These issues are addressed further in Chapter 6 on quality standards and measures and Chapter 12 on monitoring access and financial liability for Medicare beneficiaries.

A Monitoring Strategy

A strategy to monitor such changes should examine overall national trends, as well as patterns of change in specific local markets, which is where plans and beneficiaries would be responding to changing capitation payment rates. Markets selected for monitoring should be those that were expected to experience the largest effects of payment policy changes or that represented other important policy issues for a Medicare health-plan program. Such markets would include:

- markets with large changes in rates, either upward or downward, as a result of the new payment method;
- markets with high payment rates that would decline under the new payment method;

- rural areas, both those adjacent to urban areas and in more remote locations;
- markets with high Medicare enrollment rates; and
- markets with high overall penetration of managed care but low rates of Medicare risk-program enrollment, or vice versa.

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Promoting Quality of Care

Restructuring the Medicare program to increase beneficiaries' health plan options would create opportunities for enhancing the current quality assurance system. At the same time, it would also likely require modifying that system. With the proposed changes in Medicare, more beneficiaries would be expected to opt for alternatives to traditional fee-for-service Medicare. Mechanisms would be needed to support the provision of quality health care through private health plans participating in Medicare. Further, if new kinds of plans or untested ones join the program, Medicare's quality assurance system will have to accommodate a broader array of plans.

Given the rapid evolution of techniques for quality assurance, legislation that broadens health plan options for Medicare beneficiaries should provide general standards for promoting quality of care, rather than establish detailed legislative requirements for participating health plans. In devising the approach to quality assurance outlined in recommendations below, the Commission built on its previous work to develop a quality assurance system for Medicaid and for health plans in the context of proposed health system reform (PPRC 1992a; PPRC 1994). This approach also incorporates findings from the Commission's review of evolving quality assurance and improvement methods (PPRC 1995).

This chapter includes:

- *Uniform standards for all health plans*
- *Health plan performance measurement and reporting*
- *Health plans' internal quality assurance programs*
- *External quality review*
- *Data needs for quality assurance*

Recommendations

All health plans that serve Medicare beneficiaries should be subject to the same standards to promote quality of care. Specific methods for meeting those standards may differ as appropriate, given differences in plan design.

Medicare restructuring legislation should require all health plans serving Medicare beneficiaries to participate in an audited system of consumer-oriented performance reporting that emphasizes measures of health care quality.

All health plans that serve Medicare beneficiaries should be required to maintain internal quality assurance programs. Medicare's requirements for these internal programs should be consistent with established private-sector requirements, where they exist, and should reflect differences in plan design as appropriate.

All health plans that serve Medicare beneficiaries should be subject to external quality review by an independent entity approved by the Department of Health and Human Services. Plans' internal quality assurance programs should be subject to periodic external review to verify that they meet established standards. External review should also include collaborative efforts to assess and improve quality of care on a continuing basis. Quality indicators and performance measures developed specifically for the Medicare population should be incorporated into external quality review activities.

Consumer protection requirements to foster quality of care should apply to all health plans that serve Medicare beneficiaries. Plans should be required to maintain procedures for beneficiary appeals of plan decisions not to provide or pay for a service, for timely resolution of beneficiary and provider grievances, and for notification of beneficiary rights and responsibilities.

This chapter describes a framework for quality assurance in a restructured Medicare program that offers a more diverse set of health care delivery arrangements than under current law. Following a brief overview, the chapter discusses the rationale for holding all participating health plans to the same standards for quality of care, recognizing that different types of plans may need to use different methods for meeting those standards. Health plan performance measures and their applications for current quality assurance approaches are described next. The chapter then makes a case for providing consumer-oriented health plan performance reports to aid informed beneficiary choice and thereby promote quality. Both internal and external quality assurance approaches are described, and a role for these approaches in a restructured Medicare program is proposed. The chapter concludes by discussing data needs for quality assurance activities and a plan for additional work to assess plans' data capabilities.

QUALITY ASSURANCE IN MEDICARE: BACKGROUND AND OVERVIEW

A quality assurance system provides a vehicle for the Medicare program to meet its responsibility to protect and promote the quality of care furnished to beneficiaries, a responsibility that is similar to that assumed by private-sector employers in their efforts to seek maximum value for their health care expenditures. Medicare's current quality assurance system encompasses approaches for fee-for-service care and for the few types of managed-care plans now available to beneficiaries. The system involves a number of components, including institutional accreditation, health plan licensure, plan certification and periodic review, internal quality assurance program requirements, and external review of the quality of care provided in traditional Medicare and in the managed-care plans. Medicare's quality assurance system

for its participating health plans has focused on ensuring that plans have the necessary structures and activities in place to provide quality health care. Employers and other purchasers in the private sector have improved on this approach by working with health plans to develop techniques for measuring performance and quality of care.

Under a restructured program, Medicare's obligation to protect and promote the quality of care furnished to beneficiaries would continue. Disclosure of information about the quality of care provided in alternative health plans could potentially enable consumers to make their own determinations of value, but the ability to do so in a manner that is valid and meaningful to beneficiaries is still limited. At least for the near future, a restructured Medicare program will need to use performance reporting and disclosure in conjunction with other mechanisms, such as plans' internal quality assurance programs and external review, for promoting quality of care.

As envisioned by the Commission, a system of quality assurance under a restructured Medicare program would differ from the current system in two respects. First, Medicare's quality assurance system would be revised to accommodate a wider variety of health plan models. This would require both modifying and changing the scope of application of some current requirements.[1] Second, the system would incorporate private-sector innovations, where appropriate, minimizing duplicative requirements and promoting standardization. Doing so not only would foster a universal standard of quality for Medicare beneficiaries and private-sector employees, but also could ease the burden health plans bear in complying with the requirements of multiple payers and regulatory entities.

UNIFORM STANDARDS FOR QUALITY

The goal of a quality assurance system under a restructured Medicare program would be to promote quality of care in all health plans that serve beneficiaries, regardless of differences in delivery model. This goal may best be achieved by establishing uniform standards for quality that could be attained through methods adapted for the various kinds of plans that would participate in a restructured Medicare program.

Although establishing one set of quality assurance methods for all types of plans might appear to be the most equitable, flexibility could be justified by differences in plan design. Under a restructured Medicare program, plans could range from unrestricted fee-for-service plans that pay claims without constraints on utilization or choice of provider to staff-model health maintenance organizations (HMOs) that employ a variety of care-management techniques. These types of health plans vary in their ability to monitor and influence quality, and therefore quality assurance methods are not universally suitable.

Under a restructured Medicare program in which all types of health plans would be paid a capitated amount, differentiation in methods to pay plans could not be used as an indicator of incentives for

[1] For example, as discussed later in this chapter, unrestricted fee-for-service plans that pay claims without constraints on utilization or choice of provider lack the ability to undertake many internal quality assurance activities. By contrast, managed fee-for-service plans, as discussed in Chapter 11, can undertake more internal quality assurance activities.

overprovision or underprovision of services. Before the recent rapid evolution of health plan model types, managed-care (as represented by group-model or staff-model HMOs) and traditional fee-for-service plans could be clearly differentiated on the basis of plan payment systems. While plans that were paid on a capitated basis raised concerns about possible incentives for underservice to patients, unrestricted fee-for-service systems evoked opposite concerns about overutilization of services.

A distinction might be made among plans based on how they pay providers. Those that reimburse on a pure fee-for-service basis provide incentives to overserve. By contrast, those that pay providers either on the basis of capitated amounts or fee for service with withholds or bonuses create incentives to underserve. Few plans can be neatly categorized by their approaches to provider payment, however, since even among managed-care plans, the payment methodology is quite mixed. Of the managed-care plans surveyed in a recent study conducted for the Commission, 60 percent used capitation, withholds, or bonuses to pay primary care providers; 32 percent used these payment techniques for specialists (Gold et al. 1995).[2]

As for quality assurance, perhaps the most important way to characterize plans is by whether or not they establish formal relationships with providers. This, in fact, may be the crucial factor in determining a plan's ability to manage care and affect its quality. Such a relationship could take the form of contractual arrangements with selected providers, or, as in the case of staff-model HMOs, could be a direct employment relationship. A provider network enables a plan to select and retain those providers who practice in a manner compatible with the plan's care management and quality improvement efforts. Established relationships with providers also permit a plan to use both financial and nonfinancial incentives to influence the provision of care in ways that are not available to nonnetwork plans. Having a network of providers allows plans to use medical management techniques like quality monitoring, practice profiling, clinical practice guidelines, and utilization review, more effectively.

Although the ability of nonnetwork plans to use these approaches is substantially limited by lack of contractual relationships with providers, some techniques can indeed be used. Innovative fee-for-service plans, for instance, have adopted some methods for influencing costs and quality, such as case management, rebundling of services, provider profiling, and use of practice guidelines (Dyckman and Knowlton 1996).[3]

These differences in plans' abilities to influence providers argue for flexibility in the application of uniform standards for promoting quality under a restructured Medicare program. Specifically, different methods could apply to plans offering unrestricted use of services and choice of providers than to those that feature a network of providers. Under a Medicare program restructured as proposed in the congressional conference agreement (H.R. 2491), the former could include some types of fee-for-service

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[2] Surveyed managed-care plans included preferred provider organizations, health maintenance organizations of either the group-model or staff-model variety, and the network and independent practice association model HMOs.

[3] Some of the plans studied in this Commission-sponsored effort were preferred provider organizations, which have contractual relationships with providers. For more information, see Chapter 11.

plans, while the latter could include an array of managed-care plan options. The specific methods that could be used by network and nonnetwork plans in meeting established standards for performance reporting, internal quality assurance, and external review are discussed in the following sections.

PERFORMANCE MEASURES

Measures that can be used to assess health plans are often classified by whether they pertain to a health plan's structure or to the processes or outcomes of care provided in the plan. Measures of structure describe a plan's organizational, financial, or physical properties. These could include such items as a ratio of primary care physicians to specialists or of providers to total enrollment. Process measures furnish information on the extent to which services are provided, for example, cancer screening rates or influenza immunization rates. Outcomes measures offer a way to assess the results of care (whether provided or not), and include various rates of sentinel events, morbidity, and mortality.

Measures may be further categorized by that aspect of plan performance or type of plan characteristic they are designed to assess. Plans, purchasers, regulators, and consumers may be interested in various measures of the quality of care provided, enrollees' access to care, and the plan's financial solvency, as well as descriptive information that can be used to compare health plans.

The development of performance measures has been advanced by the Health Plan Employer Data and Information Set (HEDIS), which was driven by employers' interest in holding plans accountable for their performance. A Commission-sponsored survey of health plans found that many plans are now taking at least the initial steps toward measuring their performance according to HEDIS specifications (Gold et al. 1995). HEDIS provides indicators, standardized definitions, and—because of variation in plan data quality and availability—alternative specifications for measuring performance using the indicators.[4] The current version of HEDIS (2.5) is a set of more than 60 health plan performance measures, including those for quality of care, access and satisfaction, membership/enrollment, and finance.[5] Although this set is less than ideal in that it does not include many measures of outcomes and covers only a limited range of medical services and conditions, it represents the state of the art in performance measurement.

HEDIS performance measures were developed for use with the employed population, and therefore are not ideal for use in measuring how well plans meet the medical needs of the disabled and the elderly.[6] HEDIS measures appropriate for the Medicaid population were recently developed, however, and others are now being developed to address the medical needs of Medicare beneficiaries. In addition, the Health Care Financing Administration (HCFA) contracted with the Delmarva Foundation for Medical Care to identify a set of performance measures appropriate for use in monitoring the performance of Medicare managed-

[4] For example, a HEDIS immunization rate can be measured through medical record review or analysis of encounter data.

[5] HEDIS also specifies descriptive information to be collected in the areas of health plan management and activities.

[6] For example, HEDIS 2.5 includes measures of prenatal care and childhood immunization rates. It includes few measures of diseases that disproportionately affect elderly or disabled persons.

care plans. A subset of the identified measures for treating Medicare beneficiaries with diabetes is now being pilot-tested by 5 peer review organizations (PROs) and 23 health plans.

Health plan performance measures can be used in a number of quality assurance approaches. Measures of the quality of care provided can help a plan target areas for quality improvement and document the outcomes of improvement efforts. Such measures could also be used for external review, allowing purchasers or regulators to evaluate a plan by comparing its performance to that of other plans or to benchmark standards. Finally, performance measures could provide information to beneficiaries to assist them in selecting a health plan. Use of performance measures in these various capacities could promote the provision of high-quality care within health plans. Both fee-for-service and managed-care plans could undertake performance measurement or provide data for performance reports, although differences in data system capabilities among plans could limit the use of certain types of measures in particular contexts.

PERFORMANCE REPORTS FOR BENEFICIARIES

Performance reports eventually could be an important component of a quality assurance program because they have the potential to make the health plan directly accountable to the consumer. To facilitate competition on the basis of value, information about health plans must be made available to those selecting among them. If information is consolidated and displayed in a usable format, performance reports could help consumers to make their health care decisions.

The Commission has recommended previously that HCFA make performance reports available to Medicare beneficiaries to assist them in choosing among health plans (PPRC 1995). To the extent that beneficiaries can interpret and act on the information provided in these reports, plans presumably would be motivated to maintain high levels of quality to compete for enrollees. Expanding the number and variety of health plan options available to Medicare beneficiaries would strengthen the argument for providing such reports.

Content of Performance Reports

The value of health plan performance reports for beneficiaries' assessments of health plans will depend largely on the extent to which the reports capture a range of important dimensions of health care quality and plan performance. A consumer-oriented report on health plans would provide both descriptive information and performance measures. Although measurement and reporting technology is still in its early stages, identification of specific content for beneficiary-oriented performance reports will be informed by recently completed research and other efforts now under way.

Once health plan performance measures applicable to the elderly and disabled populations are developed and tested, additional work will be needed to assess which ones are most useful for beneficiary health plan selection. A review of the current status of health plan performance reports conducted by the Commission last year showed that plans and employers have only recently begun to make reports available to consumers and that research on consumer use of and interest in these reports has been limited (PPRC 1995). Specific research is needed on the types of health plan performance measures and descriptive

information that would be most meaningful to Medicare beneficiaries and that would best assist them in selecting a health plan on the basis of quality or value. In implementing a performance measurement and reporting system, the relative value of alternative measures and reporting formats could be assessed by allowing initial variation in these across, but not within, markets.[7]

Issues for Performance Reporting

A number of issues will need to be addressed in implementing a health plan performance reporting system for Medicare. First, steps will need to be taken to ensure comparability of data on health plan performance. Where comparability is sought, measures and measurement methods will need to be standardized. The ability to standardize measurement methods is now limited by wide variation in the type and quality of data collected by health plans, as discussed below. Comparable performance reports will also need to present results that are adjusted for the underlying differences in plans' enrollees that influence the outcome of performance measurement. Finally, the information in performance reports must be accurate and valid if reports are to be a useful resource. To protect the integrity of the reporting system, auditing by an independent entity will be required where self-reported performance data are used.

MEETING QUALITY ASSURANCE STANDARDS

Established approaches to quality assurance, including both quality programs internal to plans and external review, could provide a strong foundation for a quality assurance system under a restructured Medicare program. Both internal programs and external review have evolved significantly in recent years. The incorporation of performance measures relevant to the Medicare population would further enhance both of these approaches.

Internal Quality Assurance

Opportunities for health plans to operate programs to ensure and improve their quality of care differ significantly for network and nonnetwork plans. Since effective programs rely heavily on the participation and support of the plan's providers, a plan lacking a formal relationship with providers has a much more limited repertoire of mechanisms.

Programs for Network Plans. Standards established by employers and public programs reveal widespread agreement on the need for managed-care plans to have internal quality assurance programs and, generally, on the basic elements of those programs. While purchasers and government entities originally maintained that quality assurance programs were necessary to counter the financial incentives inherent in capitated plans, now purchasers are using these programs as ways to build ongoing attention to quality into plan operations.

Standards for health plans' internal quality assurance programs evolve continuously with advancement in health plan data systems, the capacity for quality measurement, and quality-of-care research. To meet

[7] See Chapter 4 for a discussion of approaches to providing information on health plans to Medicare beneficiaries.

today's widely accepted standards, a health plan's quality assurance system must have several specific characteristics.[8] The plan's top management must actively support the quality assurance program and should be accountable for its efforts. An internal quality assurance program should be the foundation of the plan's quality improvement activities. That quality assurance program should continuously monitor and evaluate services, measure the timeliness and processes used in providing care, and evaluate health outcomes as the state of the art permits. The plan also needs a remediation or quality improvement process that includes assessment and followup. Finally, the plan's quality assurance program should include written utilization review protocols and clinical practice guidelines based on current standards of practice, and peer review of processes of care.

Along with specifying elements of internal quality assurance programs, currently accepted standards include additional measures for health plans to safeguard quality and protect consumers. To meet these standards, a health plan is expected to communicate effectively with enrollees about their rights and responsibilities. It also needs a timely and effective internal appeals process and must act promptly to resolve beneficiary and provider complaints raised through an internal or external grievance process. Feedback obtained through the grievance process should be used to rectify systemic problems in quality and to resolve individual concerns.

Options for Nonnetwork Plans. Because plans that lack networks are less able to influence providers, they have fewer opportunities to undertake internal quality assurance activities. Several approaches are feasible, however. These plans could, for example, provide some quality assurance through utilization review, although this approach is often employed as much for cost-control as for quality management purposes.[9] In addition, most consumer protection standards, such as processes for grievances and appeals, could apply to all plans.

Quality assurance in Medicare's unrestricted fee-for-service plans might appropriately minimize plan involvement in favor of interaction between providers and an external quality review organization designated by the Department of Health and Human Services. To undertake practice profiling, for instance, Medicare fee-for-service plans could submit information to such a designated entity, which would pool and analyze data from multiple payers for a given provider or provider group. Such an approach would arguably be both more efficient and more productive than individual plan efforts.[10]

External Quality Assurance

Besides internal quality assurance programs, Medicare, Medicaid programs, states, and employers have incorporated requirements for external review by an independent entity as a complementary approach to

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[8] The standards described are among those used by the National Committee for Quality Assurance in accrediting health plans.

[9] Managed-care plans' preauthorization programs serve a parallel purpose.

[10] For more information on the potential for profiling in fee-for-service Medicare, see the Commission's report, *Conference on Profiling* (1992b).

ensure the quality of care provided in a plan. External quality assurance sometimes focuses on the plan's capacity to provide and ensure quality medical care.[11] Along with or instead of focusing on plan capacity, other external review programs assess the timeliness, appropriateness, and quality of care provided.[12] Both types of external review may be appropriate for managed-care plans characterized by a provider network. Because, as discussed above, internal quality assurance program options for fee-for-service plans are limited, external quality assurance efforts should focus primarily on the quality of care provided in those plans rather than on their capacity to ensure quality of care internally.

The first type of external review is designed to demonstrate compliance with requirements established by the purchaser, including those for internal quality assurance programs. Depending on the requirements imposed, such a review might entail periodic inspection of the plan's internal quality assurance program, review of the provider credentialing processes, and examination of the plan's studies of access and quality. The review could also include determining whether a process for remediation of deficiencies is satisfactory and whether the timeliness and outcomes of the appeals process are acceptable. This type of external review might include on-site inspection of a plan's organization and infrastructure, review of written submissions, or audits of medical records.

A second type of external review focuses specifically on the processes and outcomes of care provided in the plan. This type of review might entail measuring quality in a specific clinical area before and after implementation of a quality improvement program. The external review organization and the health plan might work collaboratively to identify areas for improvement, select or develop measures, and collect and analyze data. Additionally, external quality review organizations might review, on a case-by-case basis, poor outcomes, such as death or disability, that occur too infrequently for statistical analysis. For these case reviews, health professionals from the external review organization would examine medical records and other relevant information to analyze the event and draw implications for quality assurance. Both of these types of studies are designed to allow for followup action, which would be assessed by the external review organization during the next review cycle.

The peer review organizations have played a central role in Medicare's system for ensuring the quality of care provided to beneficiaries in both the traditional fee-for-service program and the participating managed-care plans. The focus of their work has changed markedly in the past few years as part of an effort to improve Medicare program's quality assurance system and enhance the PRO program's effectiveness. Until recently, much of the PROs' work was to prevent inappropriate use of services through utilization review and to identify individual instances of poor quality care for focused remedial efforts or punitive responses. The PROs' fourth contract cycle, which began in 1993, represented a shift in approach to incorporate the principles and methods of continuous quality improvement. Review of fee-for-service

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[11] To date, this type of external review in the public sector has been accomplished through the certification process by which regulators ensure that plans meet established requirements for quality assurance and other consumer protections. In the private sector, this type of external review has taken the form of accreditation programs that focus primarily on a plan's quality assurance program capability and demonstrated success.

[12] For example, Medicare's peer review organizations currently provide quality of care review for both the traditional program and the Medicare managed-care plans.

care provided under Medicare now consists primarily of practice pattern profiling, assessment, and feedback to providers. Peer review organizations continue to use the case review approach to monitoring quality for risk-contract plan enrollees. The upcoming fifth cycle of contracts, however, will require PROs to discontinue that approach and undertake collaborative quality improvement projects with individual risk-contract plans.

WORK PLAN: DATA NEEDS FOR QUALITY ASSURANCE ACTIVITIES

Quality assurance approaches are particularly dependent on the availability of data. The type, quality, and comparability of data directly determine the ability of health plans to conduct internal quality assurance program activities, external quality review organizations to monitor those activities, and the federal government to provide performance reports. Current data limitations may pose a substantial obstacle for health plan performance measurement, external review, and internal programs.

One of the difficulties in designing effective Medicare managed-care policies, including those for quality assurance, is a lack of information on costs and service use that is comparable across plans. This type of information is widely available in the fee-for-service sector because providers must submit claims to be paid for the services they deliver. Capitated delivery systems, on the other hand, are paid a monthly rate regardless of their enrollees' service use. Therefore, data documenting utilization, costs of care, and patient case mix are developed only as in-house management tools or in response to other purchasers' demands for information about plan costs and performance. As more Medicare beneficiaries join managed-care organizations, the absence of these data may limit the program's ability to act as a prudent purchaser and to protect beneficiaries' access to appropriate care of reasonable quality.

Variation in the type and quality of data collected internally by health plans hampers the ability to assess and compare health plans' performance. Performance measurement can be undertaken using administrative data sets, such as enrollment or encounter records, claims data, or survey data. In recognition of the variation in plan data sets, HEDIS measurement specifications provide alternative methods for calculating most measures. To monitor health plan performance for internal quality assurance purposes, internal consistency in measurement is sufficient. To compare plan performance, however, measurement should be conducted in the same way, using data of similar quality.

Because of the importance of data for quality assurance and other activities, the Commission plans to study health plan data capabilities during the coming year. Assessment of the range of health plans' current data collection and analysis activities will provide additional insight not only on appropriate monitoring activities, but also on the value and feasibility of standardization. In addition, the Commission will examine HCFA's plans for collecting encounter data from plans with Medicare risk contracts. It may also look further at the data collection efforts of private employers and accrediting organizations as models for Medicare.

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Medical Savings Accounts

High-deductible medical savings account (MSA) plans have been proposed by the Congress as a new insurance option in Medicare. Beneficiaries choosing this option would exchange their benefits under traditional Medicare for an insurance policy with a high deductible and funds in a dedicated savings account. Individuals would pay for their own health care up to the annual deductible by withdrawing from this account or paying out of pocket. Once the deductible was met, most or all costs of covered services would be paid by the insurance policy.

MSA plans would offer beneficiaries an insurance option that is quite different from those now available under the Medicare program. Today, beneficiaries may choose to be covered by Medicare alone, by Medicare with Medigap (or other secondary insurance), or by a managed-care plan. Given these alternatives, beneficiaries must either risk potentially large out-of-pocket payments if they choose Medicare alone, or get first-dollar insurance coverage through the other options. MSAs, by contrast, would provide insurance for catastrophic costs while leaving beneficiaries financially responsible for all health care expenses below the deductible.

MSA plans appear more likely than others to experience significant favorable selection, disproportionately attracting healthy beneficiaries who use few health care services. If this option were adopted, it would be Medicare's responsibility to avoid overpaying such plans. Policies could be aimed at reducing the opportunities for self-selection and at measuring whatever selection had occurred and then adjusting payments accordingly.

Several other issues should also be considered in structuring an MSA option for Medicare. First, managed-care plans may be unable to offer MSA products because of existing legal

This chapter includes:

- *Policy issues for a Medicare medical savings account option*
- *A description of Medisave, a Medicare medical savings account proposal*
- *Estimating costs for a Medicare medical savings account plan*

restrictions on their use of deductibles and copayments. Second, beneficiaries may not be able to make reasoned decisions about the financial risk they would face if they chose an MSA without information on potential liability for balance billing. In addition, the possibility of high out-of-pocket spending raises concerns for low-income beneficiaries.

Recommendations

The enrollment and disenrollment rules of Medicare medical savings account plans should be structured to reduce the potential for risk selection. Examples of restructured rules include a minimum enrollment period of several years in an MSA or requiring beneficiaries to announce their disenrollment from an MSA one or more years in advance.

If a Medicare medical savings account option is adopted, the Congress should require studies of selection into MSA plans both to determine what effect, if any, selection has on total program outlays and to identify a way to compensate for any selection that occurs.

Medicare MSA plans, to the greatest extent possible, should be held to equivalent types of requirements as other plans for the reporting of data to Medicare.

If a Medicare MSA option is adopted, there should be no undue legal restriction of managed-care plans' ability to offer this product. Federal laws limiting deductibles and copayments or mandating benefits richer than the ones offered by Medicare should be waived for managed-care plans' Medicare MSA products. State laws should be preempted when they conflict with this provision of federal law.

Medicare MSA plans should be required to disclose beneficiaries' typical (and potential) out-of-pocket spending including exposure to balance billing. This information should be provided to beneficiaries in a uniform format so that they can easily compare insurers.

Any Medicare MSA proposal should be structured to reduce the potential for adverse effects on low-income beneficiaries, on providers who disproportionately serve this group, and on Medicaid programs.

The first section briefly discusses the main policy issues that should be considered if MSAs are offered as an option to Medicare beneficiaries. The second section of the chapter describes the current congressional Medicare MSA proposal, called Medisave. Finally, because published projections of the costs and benefits of Medicare MSA plans vary widely, the final section models beneficiaries' spending in an MSA plan under a variety of assumptions.

POLICY ISSUES FOR A MEDICARE MSA

The basic theory behind the financial performance of MSAs is simple: a large deductible encourages people to use fewer health care services. Every dollar of spending below the deductible is a dollar the beneficiary loses, either through a smaller savings account balance at the end of the year or through out-of-pocket payments during the year.

Evidence on the actual performance of MSAs in the private sector is limited because MSAs are a fairly new and unusual insurance product. Nearly all information on the performance of MSAs comes from MSA advocates, and the typical study involves small firms with a newly offered MSA (e.g., Barchet 1995). These reports have provided a very positive view of the private experience with MSAs. The American Academy of Actuaries, by contrast, judged that none of the available information on MSAs was reliable enough for actuarial estimates, and has been unable to obtain data from firms with MSAs for its own analysis (AAA 1995).

Proponents of MSAs claim additional advantages beyond lowering the demand for heath care. First, administrative costs, the "hassle" factor involved in physician compliance with insurance rules, and third-party interference in the patient-physician relationship might be reduced (Ferrara 1995). Insurers would need to process and review claims only for those beneficiaries whose expenses exceeded the deductible. Second, coverage of catastrophic costs might be improved, with the high-deductible insurance policy offering better stop-loss protection than some other insurance policies. Finally, people with MSAs might gain access to health care services not covered by their existing insurance policies since they could pay for these using the funds deposited in their medical savings account (Barchet 1995). Alternatively, they could use funds in the account to purchase other goods and services.

Opponents of MSAs point to several potential disadvantages. Reductions in service use might come through delayed treatment or less preventive care, raising costs in the long run. Favorable risk selection into MSAs might reduce the risk sharing between healthy and sicker people, thus splitting the insurance pool and increasing costs for the less healthy. The financial risks may be too large for people of modest financial means or for those at high risk for significant health care spending.

A rational assessment of MSAs for Medicare needs to consider the significant differences between the private and Medicare insurance markets. Besides the obvious difference between a younger, healthier population and an older, less healthy one, the typical private MSA arrangement differs from Medicare in several important ways. First, employers adopting MSAs usually make the MSA the only insurance option available or, at a minimum, have considerable latitude in setting employee premium contributions and MSA deposit amounts. For Medicare, by contrast, the MSA would be a voluntary choice with premiums determined by formula. This greatly increases concerns about the impact of risk selection. Second, choices in Medicare will be affected by the Medigap market, which provides beneficiaries with another option for protecting themselves against catastrophic costs and may affect risk selection into the MSA option. Third, Medicare covers a large number of low-income individuals, with roughly one in eight Medicare beneficiaries also qualifying for Medicaid. Finally, Medicare and private insurers differ in terms of many factors that may affect costs, including typical fee levels, insurance overhead, and other factors contributing to total spending.

This section discusses some policy and design issues for a Medicare MSA. The potential for significant favorable selection into MSA plans raises the most immediate policy issue of how to determine the appropriate Medicare contribution to enrollees' medical savings accounts. Other issues relate more to the design of the MSA, both in terms of guaranteeing a level playing field among competing insurers, and in considering how increased financial risk might affect the poor.

Favorable Selection

Biased selection is probably the most important operational issue in designing and implementing a Medicare MSA option. Because Medicare's capitation rates are keyed to the costs of the average beneficiary, plans attracting healthier-than-average beneficiaries would be overpaid by Medicare.

While there is the potential for biased selection under any of the options available to beneficiaries, MSA plans have unique characteristics that may make them more prone to favorable risk selection. First, as is true among the privately insured, beneficiaries with low anticipated health care costs should find MSAs financially attractive. Those who do not think that they will use much health care should expect significant funds left in the savings account at year-end. Second, unlike the privately insured, Medicare beneficiaries with high expected costs can routinely purchase protection against catastrophic costs without giving up free choice of physician. Today's well-developed Medigap market allows beneficiaries to purchase full coverage (no copayments or deductibles) for roughly $1,000. As a result, beneficiaries who anticipate significant spending in the coming year would find it cheaper to purchase Medigap insurance than to spend through a large MSA deductible.[1]

This would place MSA plans in a unique position among the insurance products from which beneficiaries may choose. They would offer a significant cash dividend for those anticipating low health care costs, but would be a relatively expensive source of coverage for those expecting high costs. That combination suggests that MSAs may have a greater potential than other options for favorable selection.

Projecting a numerical estimate of the financial impact of selection is difficult. Beneficiaries may consider many factors when choosing an MSA over other Medicare insurance options. But if they are smart shoppers for their health care coverage—selecting an MSA plan only when they expect to save money by doing so—it is straightforward to demonstrate in a realistic manner that Medicare would be making large overpayments for beneficiaries who chose this option.

First, Medicare data demonstrate that beneficiaries could easily predict their own health care spending well enough to make rational choices about MSA plans.[2] Examination of two successive years of spending data for individual beneficiaries shows significant stability in the level of spending. For example, for the 14 percent of beneficiaries with no health care expenditures in 1992, average 1993 spending was less than

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[1] This argument is stronger for higher deductibles but weaker for lower ones.

[2] The term "spending" here means the total cost of the health care services received, including Medicare payments and deductible and copayment liabilities.

$2,000, while for the 3 percent of beneficiaries who spent more than $25,000 in 1992, average 1993 spending exceeded $20,000 (Table 7-1).[3]

Table 7-1. Predicting Medicare Beneficiaries' 1993 Health Care Costs Based on Their 1992 Costs

1992 Costs	Percentage of Beneficiaries	Average 1993 Costs	Percentage with 1993 Spending Below National Average
More than $25,000	3%	$20,626	38%
$10,000-25,000	6	10,324	47
$5,000-10,000	8	6,147	60
$2,500-5,000	8	5,484	69
$1,000-2,500	14	4,111	76
$500-1,000	15	3,226	82
$250-500	15	2,462	85
$1-250	18	2,145	89
$0	14	1,937	90

SOURCE: Physician Payment Review Commission analysis of Medicare Current Beneficiary Survey.

NOTE: Costs are for Medicare covered services, and include payments made by Medicare as well as copayment and deductible liabilities paid by beneficiaries.

Second, a simple and intuitive rule can identify beneficiaries for whom an MSA would be a good financial bet. Based on these Medicare spending data, beneficiaries should opt for an MSA plan if their prior year's spending was below $1,000. In the simplest case (no changes in costs after joining the MSA), beneficiaries following this rule would gain financially.[4] Their costs would be below Medicare's total payment, leaving some free money available in their savings account (on average) after paying for their health care. In 1995 dollars, if beneficiaries followed this rule Medicare would lose roughly $2,400 for each one who chose an MSA plan.[5] That $2,400 would be transferred to beneficiaries and their insurers.

While the exact size of the projected Medicare overpayment depends on the complexities of the modeling process, the underlying argument is simple. MSAs offer a clear and largely financial choice to beneficiaries. If Medicare contributes the average value of its benefits to the MSA, it provides a significant opportunity for beneficiaries to profit from self-selection. That opportunity could easily be exploited using

[3] Because beneficiaries would know much more about their own health than just the total amount spent, these examples show the minimum level of spending predictability.

[4] More complex models of self-selection (not shown) gave essentially the same results. First, if MSAs are assumed to reduce costs, more beneficiaries would find MSAs financially attractive. But these beneficiaries still have low expected costs and there is little change in Medicare's average overpayment. Second, risk adjusting the account deposit amount based on the beneficiary's age and sex had virtually no effect on biased selection. This occurs because age and sex capture little of the variation in costs, so that within each age/sex risk-adjustment cell individuals' costs vary almost as widely as they do across the entire population.

[5] More precisely, Medicare would spend $2,400 more than it would have if these beneficiaries had remained in traditional Medicare.

the simple rule-of-thumb demonstrated above. If this occurs, Medicare would end up overpaying significantly for beneficiaries choosing the MSA.

The Congressional Budget Office (CBO) has built similar conclusions into its estimates of the effect of MSAs on total Medicare spending. The CBO's estimate of the effect of selection on outlays for Medicare-contracting HMOs is small, only a few percentage points. For MSAs, by contrast, the CBO projects that Medicare's spending for every beneficiary enrolled in an MSA would exceed the amount that it would have spent in the traditional program by a sum equal to roughly one-third of its average per capita costs (CBO 1995).

Obviously, this possibility raises a significant concern for the Medicare program. In response, the Commission has made several recommendations aimed both at reducing the chance that Medicare might spend more for beneficiaries choosing an MSA option and at refining MSA policies once the degree and effect of selection (if any) are better known. First, regulations for enrollment and disenrollment could be structured to curb the potential for selection. To accomplish this, the Congress should consider modest restrictions in the enrollment and disenrollment process for MSA plans.

In addition, if a Medicare MSA were offered, several steps should be taken to measure the degree of selection and to adjust Medicare MSA contributions accordingly. This would require collecting objective information that might eventually be used to change Medicare's contribution to the MSA option if evidence warranted that step. To be most useful, however, studies of selection should be conducted soon after a Medicare MSA is offered.

Various sources of information might be available for monitoring the selection effect, if any, among MSA plans including the health care spending of beneficiaries in such plans before and after they enrolled, morbidity and mortality rates once they enrolled, and information on the level of account balances at year-end. Any approach, however, would require having comparable information from plans offering MSAs and from those that do not. The Commission therefore proposes that MSA plans report the same information required of other types of plans. Additionally, it may be reasonable to require additional data unique to the MSA option, such as information on account balances.

Who Would Offer Medicare MSA Products?

A basic design issue to address is the types of insurers that would offer high-deductible MSA plans. Most analyses assume that MSAs would be offered by private indemnity and preferred provider organization (PPO) insurers (Ferrara 1995). These insurers have the most experience structuring payments under a framework that uses a deductible.

Managed-care organizations could, however, offer an MSA plan. Integrating managed care within the framework of MSAs would be a more difficult approach, however, both legally and operationally. Federal and many state HMO laws would most likely have to be modified, since federally qualified HMOs are prohibited from charging an "all-purpose" deductible. High deductibles run counter to the managed-care philosophy, which traditionally emphasizes comprehensive benefits, little or no cost sharing, and greater use of preventive care.

The American Academy of Actuaries (1995) has outlined a few potential approaches for integrating MSAs within a managed-care environment. For example, enrollees would receive their care from the plan's network of providers, with restrictions placed on the use of MSA funds for nonauthorized or noncovered services. HMOs would develop a schedule of charges that could be set below the prevailing fee-for-service charges. Enrollees would pay for these services from their MSA funds. The HMO could stipulate that MSA money spent on out-of-network providers or noncovered services would not fully apply toward the deductible, whereas all funds spent on in-plan providers would.

The Commission has concluded that if MSAs are offered, all types of health plans participating in Medicare should be allowed to offer MSA products to Medicare beneficiaries. This would not only increase the competitiveness of the MSA market, but would also offer a greater range of choices if these plans reflected the managed-care philosophy of preventive care and management of disease.

Disclosure of Balance Billing and Other Financial Liabilities

One of the potential advantages of a Medicare MSA is the improved coverage of catastrophic costs. Beneficiaries cannot, however, determine their true financial liability unless they know in advance whether their insurance pays all bills, or leaves them open to balance billing liabilities. To the extent that balance billing liabilities do not count toward the deductible or are not covered above the deductible, costs are shifted toward direct out-of-pocket payments by the beneficiary.

Within the context of expanding Medicare options, MSA plans would likely vary with regard to level of deductible, required use of network providers, and provider payment policies, which would in turn affect beneficiaries' financial liabilities. Since plans could adopt different policies for determining whether particular outlays count toward meeting the deductible or are covered above the deductible, beneficiaries' liability could vary across apparently similar plans.

The Commission recommends that MSA insurers be required to disclose, as part of their marketing materials, the beneficiary's potential for balance billing liabilities or copayments that would result in out-of-pocket costs. The Medicare program would also have a legitimate role in monitoring and adjudicating beneficiaries' complaints regarding denials of coverage, as is now done for those enrolled in Medicare risk-contracting plans.

Financial Liabilities and Low-Income Beneficiaries

Medical savings accounts raise several complex issues regarding low-income beneficiaries. These beneficiaries may be the least able to assume the financial risks involved with an MSA, and are the most likely to be unable to pay bills in the event of a major costly illness. In addition, health care for the poor is funded through various sources, requiring some consideration of how MSAs might affect the programs and providers now serving the poor.

Opponents of MSAs have raised a general concern that MSAs would result in the underuse of medically needed care. MSAs are designed to create a trade-off between spending on health care and spending on other goods and services. Beneficiaries might delay treatment for serious conditions, or use less preventive or medically necessary care, thereby compromising their health status.

Both theory and evidence suggest that this is more of a concern for low-income beneficiaries than for others. Common sense suggests that low-income beneficiaries may be less willing and able to purchase needed care. For the poor, the alternative to spending the account balance for health care may be spending for necessities such as food and shelter, and there may be few assets available to cover any gap between the account balance and the deductible. Evidence from the RAND Health Insurance Experiment also suggests that low-income beneficiaries with health problems would experience diminished health status when faced with a high deductible. The RAND Health Insurance Experiment found that high cost sharing had no impact on the health status of an average person, but that the health care of poor individuals with pre-existing health problems improved under plans with little or no cost sharing (Newhouse 1993).

The second question raised by MSAs and low-income beneficiaries is the issue of coordination of coverage. These beneficiaries receive care through a variety of tax-funded and privately funded sources, including state Medicaid programs, publicly funded clinics and hospitals, and privately funded institutions offering free or reduced-price care for the poor.

There is no easy solution for coordinating the coverage of low-income beneficiaries who enroll in an MSA plan. It would appear unfair for them to retain the MSA deposit and continue to use sources of free care or reduced-price care. On the other hand, preventing these beneficiaries from using these sources of care may create its own problems. For one, it may cut off a source of revenue for providers who serve a large number of low-income beneficiaries. It might also exacerbate access problems for poor beneficiaries with MSAs who experience a significant illness, since they might find themselves both unable to purchase care and unable to use sources of free care. It might also bar beneficiaries from using the only readily available sources of care if the only local providers are those who disproportionately serve the poor.

At this point, the Commission can offer no concrete solutions to these potential problems. But this is clearly an issue for which there is little guidance from private-sector MSA implementation, and which requires significant additional study in the context of the Medicare program. At a minimum, the Commission recommends coordination of coverage between Medicare, Medicaid, and other tax-funded sources of care before implementation of a Medicare MSA option.[6]

MEDISAVE

The recent congressional conference agreement (H.R. 2491) created a proposed MSA option for Medicare beneficiaries called Medisave. This section describes Medisave and then briefly summarizes the Commission's recommendations in this area.[7]

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[6] Coordination of benefits might also require clarification in other cases where beneficiaries have multiple sources of insurance, for example, when they qualify for veterans' benefits or are employed and have Medicare only as a secondary insurer.

[7] The conference agreement defines two different MSAs: a high-deductible MSA (the subject of this chapter) and a "rebate MSA" (not discussed here). The rebate MSA is a tax-sheltered way for beneficiaries to receive cash rebates from Medicare-contracting plans.

Medisave consists of two parts: a high-deductible insurance policy and a special tax-advantaged savings account. Under Medisave, the beneficiary would choose a high-deductible insurance plan and establish a medical savings account.[8] Medicare would then make two payments. First, it would pay the premium for the high-deductible insurance. Then, any remaining funds would be deposited into the beneficiary's savings account. Medicare's total payment (premium plus account deposit) would be set roughly equal to average spending per beneficiary in the traditional fee-for-service Medicare program.

The legislation sets minimum standards for what plans must recognize as expenditures counting toward the deductible, and what amounts plans must reimburse for care above the deductible. The MSA plan must cover at least those services included under traditional Medicare, but may also pay for additional items. Costs above the deductible are insured, but may be subject to balance billing. If a provider's charges exceeded Medicare's allowed rates, the insurer would not have to count that excess amount toward the deductible or reimburse the difference, though the insurer could do this.

A Medisave plan can have any deductible up to $6,000. This upper limit would rise to keep pace with allowable cost growth under Medicare. Although the intent of the law is clearly to encourage high-deductible insurance policies, there is no specified minimum deductible.

The medical savings account itself would be managed by some fiduciary organization. This could be a bank or other traditional financial institution, but in practice the organization offering the high-deductible insurance might also manage the account. Account trustees must report annually to both the Secretary of Health and Human Services and the account holder regarding the balance in the account and any account transactions.

Withdrawals from a Medisave account could be made for so-called qualified medical expenses or for other goods and services. Qualified medical expenses would include traditional medical care services and equipment as well as payments for long-term care insurance, but not for any other type of health insurance.[9] Withdrawals for anything other than qualified medical expenses would count as gross income and therefore would be taxed at the same rate as the beneficiary's personal income. There would be an additional tax penalty if withdrawals for nonmedical expenditures were greater than the excess funds in the account at the start of the year. (Excess funds are defined as any amount above 60 percent of the deductible that applies for that year.) This penalty would be waived if withdrawals were made after the account holder became disabled or died.

Risk adjustment of Medicare's payments under the MSA option is complex. Medicare's premium payment to the MSA plan would reflect beneficiary risk factors such as age or sex, exactly as is done now with Medicare payments to managed-care plans. For example, Medicare would pay more for older beneficiaries. But only the premium payment would be adjusted, not the account deposit. All beneficiaries

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[8] In practice, establishing the account and selecting the insurer would probably be combined in a single administrative process.

[9] Qualified medical expenses for MSAs would be determined using the same definitions in the Internal Revenue Code that currently govern the deductibility of health care expenses.

in a given market area choosing a particular MSA product would receive the same account deposit. (Different MSAs would, of course, have different deposit amounts.) In effect, an MSA plan would "bid" a deposit amount based on the average beneficiary it expects to enroll.[10]

Enrollment rules under Medisave would not differ substantially from the rules governing other options, though there would be no 90-day grace period for disenrollment from Medisave. That is, once enrolled, beneficiaries would have to stay a full year. In addition, Medisave would not be immediately available for special enrollment cases such as beneficiaries who moved and needed to enroll in a plan at their new location.

Medisave plans would be open to all Medicare beneficiaries except retired federal workers, who would be excluded because of legal requirements that Federal Employees Health Benefits plans pay their Medicare deductibles. Dually eligible Medicare/Medicaid beneficiaries apparently would be free to accept the Medisave option, though there is no language requiring Medicaid programs to contribute to the beneficiary's Medisave account in lieu of traditional Medicaid coverage.

Medisave insurers would be subject to some (but not all) of the regulations that apply to other plan options. Marketing and solvency standards would apply uniformly, but Medisave plans would not be subject to a minimum enrollment requirement. Nor would they be subject to the adjusted community rating process that requires other plans to rebate any difference between Medicare payments and an estimate of costs plus normal markup. Medigap insurers would be forbidden to offer policies to beneficiaries choosing Medisave.

The discussion of issues and Commission recommendations in the previous sections of this chapter suggest several areas where the Medisave proposal should be modified. First, concerns about favorable risk selection into MSA plans should be addressed through enrollment rules, data reporting requirements, and mandated research. Second, if MSAs are offered in Medicare, federal laws regulating managed-care plans should be modified to allow them to offer MSAs. Third, beneficiaries should be fully informed about out-of-pocket costs. Finally, the likely effects of Medisave on the poor and on programs such as Medicaid and publicly funded providers should be addressed.

ESTIMATING COSTS FOR A MEDICARE MSA PLAN

The following discussion analyzes the financial aspects of a Medicare MSA plan. It identifies the factors that are likely to have a significant effect on spending and then presents a range of estimates of beneficiaries' spending and financial risk.

The first part of this section identifies the assumptions required to project beneficiaries' spending and financial risk in a Medicare MSA plan. Most analyses of MSAs have focused on the potential for a high

[10] Earlier bills would have risk adjusted both the deposit amount and the premium payment. In theory, this would be preferable because it might reduce selection. As discussed above, however, risk adjusting the deposit has only a marginal effect on the potential for selection. In addition, risk adjusting the deposit amount would make MSAs look complex to beneficiaries because there would be 60 different deposit amounts for the 60 different risk categories now used in the Medicare program.

deductible to reduce service use, but that is only one of many important factors that would affect spending under this option in Medicare. Other significant financial factors include changes in the price paid per service, the cost of insurance overhead, and the scope of services covered.[11]

The second part of this section provides numerical estimates of spending and beneficiaries' financial risk under a Medicare MSA. The section shows the entire calculation, starting from current Medicare spending patterns and arriving at estimates of MSA deposit amounts and beneficiaries' costs. Some "middle of the road" assumptions regarding costs and revenues yield an estimate that beneficiaries might save several hundred dollars on average if they are willing to risk a few thousand dollars in out-of-pocket expenses. This estimate is roughly similar to a recent Kaiser Family Foundation analysis (Rodgers and Mays 1995), but is much less optimistic than estimates produced by the National Center for Policy Analysis (NCPA 1995).

Factors Affecting the Financial Performance of a Medicare MSA

Projecting beneficiaries' health care spending and the size of account deposits under a Medicare MSA involves a number of significant assumptions about both costs and revenues under this option. The impact of a high deductible is unique to the MSA approach, but other factors must also be considered based on the differences between private insurance payment rules and payment rules used in the Medicare program.

Impact of High Deductibles on Volume of Care. Use of a high deductible is the defining attribute of the MSA insurance model, and the one that typically receives the greatest attention. There is a significant amount of evidence that cost sharing reduces the demand for health care services.

Estimates of the effect of cost sharing on patients' medical care use are often based on data collected in the 1970s and early 1980s as part of the RAND Health Insurance Experiment. This study showed that as coverage varied from no copayment to 25 percent copayment, use fell by 19 percent, and that moving from no copayment to a large deductible resulted in a 31 percent reduction in use (calculated from Newhouse 1993).

Studies on the effect of secondary insurance on Medicare beneficiaries' use of services show similar effects. Beneficiaries without secondary insurance (who thus cover copayments and deductibles out of pocket) used significantly fewer Medicare services (Chulis et al. 1993; McCall et al. 1991; Taylor et al. 1988; Christensen et al. 1987; Link et al. 1980).[12]

The degree of agreement among estimates suggests that some significant reduction in volume of care is likely under high-deductible insurance, but there may be some reasonable uncertainty about the size of the reduction. None of the estimates in the literature corresponds exactly to the Medicare MSA. The RAND

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[11] This section focuses on the short-run effect on spending and does not consider the much more speculative issue of whether short-run savings through reduced service use create the potential for long-run cost increases because of delayed treatment or reductions in preventive care.

[12] Chapter 16 provides a detailed estimate of the effect of secondary insurance on the use of different types of services.

data are more than a decade old and were for a nonelderly population. The Medigap analyses examine beneficiaries facing deductibles and copayments rather than the one large deductible of the Medicare MSA.

At least three other factors suggest that the likely effect of MSAs on Medicare beneficiaries' utilization may differ from these reported effects. First, there is a potentially significant tax issue. Spending from the MSA for health care would be nontaxable but spending from the MSA for other goods and services would count as taxable income. This means that, in effect, beneficiaries would have less than a 100 percent copayment for services incurred before the deductible was met (Pauly 1994).[13] Second, beneficiaries might choose to receive additional elective procedures once they had met their deductible, because they would be insulated from costs.[14] Finally, if the MSA were structured so that it would be difficult to spend the account balance on anything other than health care, the demand-reducing effects of the high deductible might be muted (AAA 1995).

Management of Care. A second factor that would affect the volume of care under an MSA option is private insurers' methods for improving efficiency in care delivery. This would depend, of course, on the types of private insurers offering MSA options. Indemnity insurers have begun adopting case management and network development as methods for controlling costs. Managed-care plans have added other techniques, including proactive health assessments, substitution of outpatient for inpatient care, and tighter monitoring and control of chronic illness. In an MSA plan, more efficient delivery of care could lower service use after the high deductible was met.

Breadth of Coverage. A third factor affecting volume of care under the MSA option is the breadth of coverage. As more services count toward the deductible, total spending above the deductible increases. For example, including the cost of outpatient drugs as covered services would raise the cost of the high-deductible insurance both because more people would exceed the deductible and because each person would have higher covered costs.

Price per Service. Today, Medicare pays substantially less than the average private payer for many services. For hospital inpatient care, Medicare in 1993 paid slightly less than hospitals' costs while private payers paid about 29 percent more than hospitals' costs (ProPAC 1995). For physicians, Medicare is estimated to pay roughly 71 percent of national average private fees (see Chapter 12).

This raises an obvious empirical question about how removing these discounts might affect total spending. Costs below the deductible would depend on the extent to which individual beneficiaries or their MSA

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[13] For example, if the beneficiary is in a 25 percent tax bracket, each $1 reduction in health care spending out of the MSA would liberate only 75 cents in after-tax money to spend on other goods and services. Stating that another way, each $1 in health care spending costs only 75 cents in after-tax income, so the effective copayment rate is 75 percent, not 100 percent.

[14] This effect was found in the RAND Health Insurance Experiment, with the under-65 population using much more dental and well-care services and somewhat more of other services once the deductible had been met (Newhouse 1993). This effect might plausibly be larger for the elderly because they have many more problems that can be met through expensive elective procedures, for example, cataract surgery or hip replacement.

plans are willing and able to extract price concessions from physicians, hospitals, and other providers. Above the deductible, prices would depend on MSA insurers' ability to both pay low rates and limit balance billing of beneficiaries for any difference between payments and providers' charges.

The national average fee levels obscure variation across regions and payers. Areas with excess supply of providers and aggressive managed-care plans may have private payment rates that are lower than Medicare's rates. This suggests that MSAs might be more successfully offered in areas with widespread private-sector price discounting, assuming that the MSA is offered through a selectively contracted network of discounted providers. In the absence of discounting arrangements, costs in MSA plans would be high in markets where physicians' charges were significantly higher than Medicare fees or prevailing private-sector discounts.

Overhead Costs. Insurance overhead also would affect total costs in an MSA plan. Medicare's overhead costs are nominally in the range of 2 to 3 percent. Typical private insurance overhead is higher, particularly for policies marketed to individuals. While MSAs might reduce claims-processing costs relative to other private payers, it is likely that other costs such as advertising, enrollment, and profit would result in overhead that is significantly higher than Medicare's.

Recovery of Secondary Insurance Premiums. Calculation of the costs and benefits of a Medicare MSA must account for all current spending on behalf of beneficiaries. This includes the amounts that beneficiaries spend now for deductible and copayment liabilities, or, alternatively, the secondary insurance premiums covering those liabilities. Recovery of premiums formerly spent on secondary insurance is a critical revenue-side issue for the attractiveness of the MSA, and can often be the beneficiary's single largest source of funds for covering costs below the deductible.

These funds may not literally be deposited into the medical savings account, but for clarity of exposition these funds are counted as revenues under the MSA option (see below). In some cases, such as employer contributions to the MSA, these might literally be payments to the beneficiary. In other cases, such as cancellation of a Medigap policy, these are merely costs that the beneficiary would no longer bear once enrolled in the MSA plan.

Determining the average recovery of funds raises two questions. The first is a practical question: how can beneficiaries recover premiums other than Medigap (for example, premiums that employers now pay to provide supplemental coverage as a retirement benefit). The second concerns typical loading (markup) on premiums averaged across all the types of secondary insurance that beneficiaries hold.[15] Because Medicare beneficiaries may have secondary insurance through a variety of sources (Medigap, retirement benefit, Medicaid), or may have no secondary insurance, analysis of this issue is complex.

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[15] Insurance premiums include loading (markup) to cover administrative costs and profit. Beneficiaries canceling insurance policies would therefore recover not only the value of the average copayment and deductible, but this loading as well. Data on typical loading allows one to develop an estimate of premiums consistent with the Medicare spending data that form the basis for the analysis presented below.

Some 44 percent of beneficiaries have individual Medigap policies.[16] Recovery of funds in this case is easy; beneficiaries no longer buy the insurance and instead keep the premium dollars.[17] The only empirical question would be the average loading factor for these policies. Based on a recent study by the United States General Accounting Office (GAO), the average premium loading on Medigap policies from 1991 to 1993 was about 22 percent.[18]

Another 42 percent of beneficiaries have secondary insurance as a retirement benefit.[19] Recovery of those funds assumes that employers would contribute the value of premiums to the retirees' MSA. Estimating the funds recovered would require applying typical employer-sponsored insurance loading rather than typical Medigap loading, and would have to account for the mean level of generosity of the secondary coverage.[20]

About 10 percent of beneficiaries have no secondary insurance and hence no premium loading. Estimating their average MSA funds requires calculating average deductible and copayment liabilities, less any forgiveness of copayment or bad debt that occurs under the current system.

Finally, 12 percent of Medicare beneficiaries have Medicaid as their secondary insurer. Many Medicaid plans do not pay the full value of copayments, but instead pay only the difference between the Medicare payment amount (80 percent) and their own fee schedule amounts. Estimation of the total monies involved would require calculating actual Medicaid expenses for coverage of copayment liabilities, as well as typical Medicaid overhead. This is complicated by the fact that Medicaid's financial responsibility differs across groups of affected beneficiaries, from paying premiums only to paying all required premiums and cost-sharing. Recovery of those monies assumes that Medicaid would contribute to the MSA.

Other Factors. At least two other factors may have a significant influence on the beneficiary's costs in the MSA but are not considered in this calculation. First, risk selection could clearly have a very large impact on spending and costs, as discussed above. The deposit offered by an MSA plan would reflect not only the plan's efficiency, but also any reduction in average costs that occurs if the plan disproportionately attracts good insurance risks.

Second, these calculations do not include any allowance for balance billing amounts. The MSA insurer may or may not count payments made by the beneficiary that exceed the insurer's own fee schedule. To the extent that these balance billing amounts are not counted by the MSA insurer, beneficiaries' out-of-pocket costs would increase.

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[16] See Chapter 16 for information on the proportion of beneficiaries with secondary insurance.

[17] This statement is a simplification: coverage for items other than copayments (such as outpatient drugs) would have to be considered separately.

[18] This is calculated from data in GAO 1995.

[19] About 7 percent have both employer-provided and Medigap policies.

[20] Employers may or may not be willing to contribute their full current premium equivalent to the MSA option. Information on employers' typical contribution may give some market-driven indication of their estimates of self-selection into this option. Employer contributions also raise an important tax issue, because payments from the employer to the retiree in lieu of insurance coverage are currently counted as taxable income.

Projecting Beneficiaries' Financial Position in a Medicare MSA Plan

The preceding discussion shows that there will be significant uncertainty in any estimate of the amount that a Medicare MSA will pay out to beneficiaries. This section presents a range of numerical estimates of MSA spending and beneficiary financial risk for an MSA with a $3,000 deductible.

The calculation proceeds in two steps. First, no changes in cost are assumed, and current dollars are merely reshuffled into spending below $3,000 (to be paid by the beneficiary) and spending above $3,000 (to be paid by the insurer). This step shows the basic outline of the calculation and provides a neutral baseline prior to making assumptions about the changes in spending that might occur with the MSA plan. The second step shows beneficiaries' average savings and risk when specific values are assumed for changes in volume of care, price per service, and insurance overhead costs.

Baseline Estimate: No Cost Savings. The calculation of the spending baseline for a Medicare MSA starts from data on current spending for individual beneficiaries. (Spending includes both Medicare's payments and the beneficiary's copayment and deductible liabilities.) The calculation proceeds by estimating the premium for the high-deductible insurance, calculating Medicare's deposit into the MSA, then summarizing the beneficiary's average financial position and financial risk.

The Medicare Current Beneficiary Survey (CBS) is a convenient source of data on spending for about 12,000 Medicare beneficiaries. The CBS administrative record summarizes total Medicare Part A and Part B payments, along with total beneficiary liability for copayments and deductibles.[21] For this analysis, data from the 1993 CBS were inflated to match Medicare spending of $5,000 per beneficiary, roughly the correct level for FY1995.[22]

Medicare data exhibit the well-known skewed distribution of health care spending. The top 1 percent of beneficiaries (those with total annual outlays above $63,300) account for 18 percent of annual spending; the top 5 percent (those with total annual outlays above $29,300) account for almost half of all spending (Table 7-2).[23]

The initial step of the calculation is to estimate the cost of the high-deductible insurance. Each beneficiary's current (1995) spending is put into two categories: below and above a $3,000 cutoff. For example, if a beneficiary used $10,000 in health care services in 1995, that would be divided into $3,000 under the cutoff and $7,000 over the cutoff. Averaging this across all beneficiaries gives a baseline estimate of how much spending would occur below the deductible (to be paid by the beneficiary) and

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[21] The CBS files used in this analysis include individuals who were sampled but did not respond to the survey. It is very important to include these non-respondents because they include many beneficiaries who died during the year and consequently had high costs.

[22] This may overstate 1995 copayment and deductible spending not only because the Part B deductible is fixed, but also because some fast-growing Medicare services such as home health care have below-average copayment liabilities.

[23] The highly skewed distribution makes it important to focus on average spending. As a matter of arithmetic, spending by the typical (median) beneficiary is far below average spending (total spending divided by the number of beneficiaries).

Table 7-2. Estimated Distribution of Spending among Medicare Beneficiaries, 1995

Percentile of Beneficiaries	Cumulative Percentage of Expenditures	Per Capita Costs at Percentile Boundary
1st	18%	$63,300+
5th	46	29,300+
10th	64	16,500+
25th	88	4,900+
27th	90	4,000+
31st	92	3,000+
50th	97	1,000+

SOURCE: Physician Payment Review Commission analysis of Medicare 1993 Current Beneficiary Survey, inflated to 1995.

NOTES: Spending is for Medicare covered services, and includes payment made by Medicare as well as copayment and deductible liabilities paid by beneficiaries.

Average total spending was $5,970.
Average Medicare spending was $5,000.

above the deductible (covered by the high-deductible insurance) if there were no changes in use of services.[24] The "premium" for the high-deductible insurance is set equal to the cost of those services.

The skewed distribution of health care spending results in a high fraction of spending occurring above the deductible. Most spending is incurred by a few persons with very high costs; consequently, most spending occurs above the deductible for these individuals.

Current patterns of spending show that about three-quarters of all outlays would have occurred beyond the $3,000 threshold (Table 7-3).[25] Out of total spending of $5,970 per person, $4,540 would have occurred above the deductible.

Converting the spending distribution into an initial estimate of Medicare's MSA deposit is straightforward (Table 7-4). Spending above the $3,000 threshold reflects the services that would be covered by the high-deductible insurance policy. Medicare's contribution is the difference between current Medicare outlays ($5,000) and the premium for the high-deductible insurance ($4,540). This leaves $460 to be deposited in the beneficiary's MSA (Table 7-4).[26]

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[24] This calculation must be done separately for each individual and then averaged. To continue the example above, if half of beneficiaries spent $10,000 and half spent $0, average total spending would be $5,000 ($10,000 ÷ 2), average spending below the deductible would be $1,500 ($3,000 ÷ 2), and average spending above the deductible would be $3,500 ($7,000 ÷ 2).

[25] This table gives a different view of spending from Table 7-2. Table 7-2 arrayed beneficiaries from most to least costly. Table 7-3 divides each beneficiary's spending into spending above and below a $3,000 threshold.

[26] Different deductibles were also modeled but not shown here. As the deductible increases, the Medicare deposit rises but not nearly as fast as the deductible. A $5,000 deductible would yield a Medicare deposit of approximately $1,000.

Table 7-3. Composition of Estimated 1995 Spending Below and Above a $3,000 Deductible (dollars)

	Medicare Payments	Beneficiary Copayment and Deductible	Total Spending
Below $3,000 Deductible	$1,010	$420	$1,430
Above $3,000 Deductible	3,990	550	4,540
Total	5,000	970	5,970

SOURCE: Physician Payment Review Commission analysis of Medicare 1993 Current Beneficiary Survey, inflated to 1995.

Table 7-4. Calculation of Medicare's Contribution to and Beneficiary Savings Associated with a Medical Savings Account with a $3000 Deduction and No Change in Costs Assumed (dollars)

Source of Funds	Amount
Funds from Medicare	
Current Medicare costs	$5,000
Less cost of high-deductible coverage	4,540
Equals Medicare's deposit to medical savings account	460
Funds from Beneficiary	
Money formerly spent on copayments and deductibles	970
Plus savings from elimination of Medigap premium loading	0
Equals total out-of-pocket funds available	970
Total Funds (Medicare and Beneficiary)	1,430
Less Total Spending Below the Deductible	1,430
Equals Average Savings to Beneficiary	0

SOURCE: Physician Payment Review Commission analysis of Medicare 1993 Current Beneficiary Survey, inflated to 1995.

Any fair comparison of spending in a Medicare MSA plan with that under traditional Medicare must account for more than just the account deposit, however. A proper comparison must contrast the amounts that beneficiaries would spend out of pocket under the MSA to what they would have spent out of pocket under traditional Medicare, that is, to average copayment and deductible liabilities in the traditional program.

The simplest way to capture this is to count beneficiaries' out-of-pocket costs under traditional Medicare as funds from the beneficiary under the MSA (Table 7-4). This provides a correct calculation of the change in beneficiaries' out-of-pocket costs in moving from traditional Medicare to the MSA. It is important to note, however, that the funds from the beneficiary are not new revenues the beneficiary would receive, but merely are costs that the beneficiary would no longer have to bear once enrolled in an MSA plan. On

average, beneficiaries would have spent $970 on copayments and deductibles.[27] Adding that to Medicare's account deposit gives a total of $1,430 available to the beneficiary (Table 7-4)

Beneficiaries' average saving is the difference between total funds available (MSA balance plus prior out of pocket) and spending below the deductible (to be paid by the beneficiary). No cost savings were assumed in this calculation, so in this case calculating beneficiaries' cost savings merely provides a check that all spending has been accounted for. In this calculation, average spending below the deductible (paid by the beneficiary) just equals the funds available to the beneficiary, so there are no savings (Table 7-4).

The average financial position does not show the degree of risk involved. The beneficiary's financial risk could be expressed in a number of ways. With no cost savings assumed, 31 percent of beneficiaries spend the full deductible amount or more (Table 7-5). That would mean a roughly 1-in-3 chance of spending $2,540 beyond the MSA balance, or spending $1,570 more than the sum of the MSA balance plus prior out-of-pocket costs.

Table 7-5. Measures of Beneficiary's Financial Risk, Medical Savings Account Baseline Calculation

Measure	Amount
Maximum Total Out-of-Pocket Costs ($3,000 deductible less MSA deposit)	$2,540
Maximum Additional Out-of-Pocket Costs ($3,000 deductible less MSA deposit plus prior out-of-pocket costs)	1,570
Probability of Hitting the Deductible	31%

SOURCE: Physician Payment Review Commission analysis of Medicare 1993 Current Beneficiary Survey, inflated to 1995.

Scenarios with Changes in Costs. The final empirical analysis of this issue consists of expanding the baseline calculation for a variety of assumptions about volume of care, price per service, overhead costs, and recovery of secondary insurance premiums. This provides estimates of the influence of each factor on beneficiaries' expected costs and financial risks within a Medicare MSA.

The outline of the calculation is identical to that of the previous section, but the data change as different assumptions are imposed. For example, the first scenario considered is the baseline calculation shown above, so that scenario A shows exactly the same numbers as were presented in Tables 7-4 and 7-5 of the previous section (Table 7-6). For the remaining scenarios, the dollar amounts change as various assumptions are imposed. For example, scenario B shows the impact of reducing Medicare's total payments by 5 percent, or $250. This passes through the calculation, resulting in $250 less in total funds available to the beneficiary, and a $250 increase in beneficiaries' out-of-pocket liabilities (Table 7-6).

[27] For ease of explanation, this initial calculation is done as if beneficiaries paid those costs directly out of pocket. The effect of loading (markup) on secondary insurance premiums is considered later.

Table 7-6. Estimates of Medical Savings Account Savings and Risk for Various Scenarios with a $3,000 Deductible

Savings Source or Measure of Risk	Assumptions						
	(A) Baseline (No Changes in Costs)	(B) Reduce Medicare Contribution by 5 Percent	(C) Recover Medigap Premium Loading[a]	(D) Volume/ Price Changes Reduce Costs by 20 Percent	(E) Volume/ Price Changes Increase Costs by 20 Percent	(F) Add Overhead Costs for Catastrophic Insurance[b]	Combined Scenario (B+C+D+F)
Saving Calculation							
Total Medicare payments	$5,000	$4,750	$5,000	$5,000	$5,000	$5,000	$4,750
Less cost of high-deductible insurance	4,540	4,540	4,540	3,450	5,640	5,450	4,140
Equals funds from Medicare	460	210	460	1,550	-640	-450	610
Plus funds from beneficiary	970	970	1,160	970	970	970	1,160
Equals total funds	1,430	1,180	1,620	2,520	330	520	1,770
Less total spending below deductible	1,430	1,430	1,430	1,320	1,520	1430	1,320
Equals average savings to beneficiary	0	-250	190	1,200	-1,190	-910	450
Measures of Risk							
Maximum total out-of-pocket costs	2,540	2,790	2,540	1,450	3,640	3450	2,390
Maximum additional out-of-pocket costs	1,570	1,820	1,380	480	2,670	2480	1,230
Probability of hitting deductible	31%	31%	31%	28%	34%	31%	28%

SOURCE: Physician Payment Review Commission analysis of Medicare 1993 Current Beneficiary Survey, inflated to 1995.

[a] 20 percent of former copayments added.

[b] 20 percent premium loading

These scenarios demonstrate the sensitivity of the financial calculation to the underlying assumptions about sources of revenue and changes in spending (Table 7-6). Some factors have only a modest effect on the calculation. For example, reducing Medicare's total contribution by 5 percent or adding in savings from recovery of Medigap premium loading (scenarios B and C) change the beneficiary's estimated savings by just a few hundred dollars. Other factors, such as the net effect of changes in the volume and price of service (scenarios D and E) can move estimated savings by more than a thousand dollars. Similarly, accounting for the overhead costs of the MSA insurer can reduce estimated savings significantly.

The final column in the table combines a number of moderate assumptions regarding costs and revenues, with reductions in payments to providers partially offset by increased insurance overhead costs. This scenario projects that beneficiaries might save several hundred dollars on average at a risk of a few thousand dollars in out-of-pocket expenses. This estimate is quite similar to that in a recent analysis by the

Kaiser Family Foundation, while it suggests a much less optimistic conclusion than estimates produced by the National Center for Policy Analysis (Rodgers and Mays 1995; NCPA 1995).

SUMMARY

Medical savings accounts would offer beneficiaries an insurance option that they do not now have in the Medicare program. In an MSA plan, beneficiaries could choose to be insured only for health care expenditures that exceed a large deductible, while paying for routine costs below the deductible by withdrawing from a dedicated savings account or paying out of pocket. This could encourage beneficiaries to be more cost-conscious in their use of services without exposing them to financial ruin in the event of catastrophic illness.

A Medicare MSA raises some significant policy concerns, however. First, a Medicare MSA plan is likely to attract significant favorable risk selection. This suggests that MSA enrollment should be structured to discourage such selection and that Medicare's MSA contribution should be set to reflect any selection that occurs. Second, if MSAs are to be offered, all types of plans should be able to compete for beneficiaries desiring this option, including managed-care plans that might now be excluded because of legal restrictions on the use of copayments and deductibles. Third, beneficiaries should be fully informed about the typical out-of-pocket costs they would incur in an MSA plan. Finally, MSAs might have adverse effects on low-income beneficiaries and on providers serving them. At a minimum, the Medicare MSA option requires coordination of coverage with Medicaid and other tax-funded sources of coverage for poor beneficiaries.

From the beneficiary's standpoint, the financial performance of a Medicare MSA option depends on a number of factors. Most of the literature on MSAs in the private sector has focused on the effect of the large deductible in reducing use of services. For Medicare, however, a number of equally important factors come into play based on the differences between Medicare's payment rules and the payment rules used by private insurers. Different assumptions can lead to widely varying estimates of the impact on beneficiaries, from significant cost savings to marked increases in costs. A Medicare MSA's costs and benefits will depend on all of these factors, as well as on the degree of risk selection that occurs.

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Medicare's and Health Plans' Coverage Decisions and the Appeals Process

Private health plans participating in Medicare do not provide or pay for some services at times on the grounds that they are not "medically necessary and reasonable," or that they are not a benefit covered under the contract. Claims can also be denied because the enrollee or provider did not follow the administrative rules of the health plan. Beneficiaries and their physicians inevitably will disagree with some of these decisions.

Federal law defines in general terms the services that must be covered by health plans under Medicare and establishes a formal appeals process to resolve disagreements about whether specific services should be furnished or paid for. This chapter suggests how to improve the appeals process and the standards that govern the rights and responsibilities of health plans and their enrollees. The process and standards should be fair, clear, and efficient. They should enable health plans to manage care responsibly while ensuring that beneficiaries receive appropriate and timely care, without imposing undue burdens on plans, providers, or beneficiaries.

The Health Care Financing Administration should continue its efforts to make more timely and nationally consistent evidence-based coverage decisions. These decisions should be communicated to private health plans that participate in Medicare and to the contractor that handles appeals of denials of service.

Recommendations

This chapter includes:

- *The rules that determine which services are covered by health plans that participate in Medicare*
- *A recommendation to revise the definition of covered emergency care*
- *Proposals to improve the appeals process available to Medicare beneficiaries when health plans decline to provide or pay for a service*

The Health Care Financing Administration, with input from beneficiaries, providers, and health plans participating in Medicare, should provide guidance on the latitude that plans may exercise in choosing among alternate approaches to care.

A prudent layperson's perspective should be considered as one of the factors in determining when a health plan that participates in Medicare should pay for initial screening and stabilization, if necessary, in an emergency.

The Health Care Financing Administration should improve the appeals system as needed for health plans participating in Medicare by:

- *encouraging plans to develop better ways to prevent and resolve disputes;*
- *requiring plans to maintain a process to resolve pre-service requests within the time period necessitated by the beneficiary's condition, and requiring its contractor to reconsider such cases, when necessary, in a similar manner;*
- *ensuring that beneficiaries are informed about these processes; and*
- *holding plans accountable for the performance of their appeals systems, in part by collecting information on plans' performance and making it available to the public.*

The first part of this chapter addresses the procedural and substantive rules used by health plans, beneficiaries, providers, and the appeals system to determine which services should be furnished. The second section analyzes how the appeals process itself can be improved.

REVISING THE RULES GOVERNING WHICH SERVICES ARE COVERED

Current law and regulation hold health plans participating in Medicare responsible for providing the full range of services available under fee-for-service Medicare Parts A and B (Richardson 1995a). This section discusses the procedural and substantive requirements that determine the rights and obligations of health plans and beneficiaries with respect to providing or receiving medical services. These rules therefore govern decisions when denials of service are appealed. Substantive restrictions on which medical services are provided or paid for can be distinguished from procedural ones on the manner in which services are provided (e.g., rules about who can furnish a service and where).

Substantive Restrictions

The medical services that insurance may cover for a patient can be described by three levels of specificity. At the most general level, benefit packages are usually described in terms of broad categories of services, such as pharmaceutical services, nursing home services, and inpatient services. The benefit package for Medicare is specified in legislation in these terms. At the next level, for each specific service within such categories, a coverage decision governs whether the service is available at all. So-called experimental services, for example, are excluded from coverage by Medicare and other payers. The Health Care Financing Administration (HCFA) makes some coverage decisions for specific services at a national level, usually by issuing regulations. In the absence of a national coverage decision, individual Medicare carriers and fiscal intermediaries interpret HCFA's coverage criteria in formulating local coverage policies that apply within their own geographic areas. The third level of specificity addresses whether a service that is covered in general will be provided for a particular patient in a specific clinical situation.

Coverage Decisions. HCFA's national coverage decisions govern not only the services available in fee-for-service Medicare, but also the minimum set of services that health plans must make available for their Medicare enrollees.[1] The Commission previously has described the need for Medicare to make more timely and nationally consistent coverage decisions based on the best available evidence (PPRC 1995). Network Design Group (NDG)—the HCFA contractor that decides appeals from coverage denials—reports that for many procedures there is no Medicare national coverage policy, and local carrier policies, if documented, may vary (Bender 1995).

HCFA has been taking steps to improve its coverage decisionmaking process consistent with the Commission's recommendations (PPRC 1995). The agency is preparing a regulation that will better define Medicare's criteria for coverage, particularly in terms of the evidence required. HCFA has also begun to contract out for technology assessments on which to base national coverage decisions (Sheingold 1996). These decisions need to be communicated better to health plans and HCFA's reconsideration contractor.

HCFA is also making local carrier and fiscal intermediary policy development more consistent and timely. The computerized database for carrier coverage policies, now called the medical policy retrieval system (MPRS), has been revised and will be administered centrally by the agency beginning in March 1996. Carriers and health plans can use this database to help them formulate consistent policies. Additionally, HCFA has formed workgroups of carrier medical directors that are drafting model coverage policies. These are sent to HCFA for approval, then distributed to the carrier medical director steering committee and the carrier medical directors. The policies will not

[1] When HCFA first decides to cover a costly new technology or service in midyear, an adjustment may need to be made to the premium paid to health plans or, as the congressional conference agreement (H.R. 2491) would require, the coverage requirement could be delayed until the next contract year.

necessarily be based on rigorous technology assessments, but they should be more consistent and timely than before.[2]

When national coverage policies do not exist for a particular service, HCFA needs to clarify whether health plans are bound by their local carrier's policy or whether they can independently interpret federal law and regulations concerning when services are covered by Medicare. It would seem that when a local carrier explicitly does not cover a service, health plans within its area should not be required to do so. When a carrier has a documented policy to cover a service, health plans should cover it or provide an acceptable alternative, as discussed below. In either event, there needs to be better communication between carriers and the health plans within their areas. For health plans that operate in multiple carrier regions, a mechanism should be created to resolve conflicts among the carriers. The same logic applies to fiscal intermediaries.

Choices among Covered Services. Inherent in the notion of managing care is the ability of health plans to select, to some extent, among acceptable alternate approaches to care. This means that access to some services that might be covered for a fee-for-service Medicare beneficiary may be restricted even if they are desired by an enrollee in a private health plan participating in Medicare. A health plan might decide, for example, that medical treatment is preferable to surgery for most patients with a given problem, permitting surgery to be used only for a narrow set of specific clinical indications. The rates at which this operation is performed may then differ between the health plan and fee-for-service Medicare.

HCFA needs to begin to address the issue of how to define an acceptable latitude for these coverage choices by health plans. Restrictions are clearly defensible when the course of care covered by the health plan produces the same or better outcomes with no greater risks or morbidity than the alternate approaches to care. Different approaches to care rarely have exactly the same mix of benefits and risks, however, and the extent of knowledge about services' benefits and risks may differ. Guidance is needed on the coverage choices that health plans should be permitted to make among alternate approaches to care. If a health plan can decide that a particular service covered under Medicare is never preferable to its alternatives, for example, the plan would effectively not cover that service for its enrollees.

Judgments about the acceptability of treatment guidelines illustrate the problem of assessing these choices by health plans. When beneficiaries (or their physicians) request approaches to care that are contrary to health plans' practice guidelines, the basis for resolving such disputes is not clear. Efforts to assess the validity of practice guidelines are in their infancy. Health plans sometimes wish to restrict use of a treatment modality for which the evidence of its effectiveness, in their view, is insufficient. At other times, health plans may craft ways to deliver care more effectively and efficiently, but a strong body of evidence will not necessarily be available to support new guidelines. Perhaps acceptance of innovative treatment policies should be predicated on some threshold amount of evidence and reasoning, plus a system of monitoring clinical outcomes so that adverse effects can be detected and corrected.

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[2] The carrier medical directors generally use national experts and interested professional groups to help them develop the policies (Olds 1996). It would seem desirable for health plans to have input into coverage policies that affect them.

These issues are likely to become more salient as enrollment in managed care increases and pressures mount to reduce the rate of growth of Medicare expenditures. The role of cost considerations in these choices is controversial, yet in many circumstances health plans may choose to provide or pay for the least costly of alternate effective approaches to care. Restricted formularies, for example, often include only the least expensive drug within a class of drugs of similar therapeutic effectiveness. It is difficult, though, to define when a service's incremental benefit is worth its added cost. Beneficiaries, providers, and health plans all have vital perspectives to contribute on these issues. HCFA, as a public payer, is well-situated to convene these groups in a manner that promotes the public interest.

Procedural Restrictions

To manage care, health plans may use such tools as gatekeepers, requirements for preauthorization, and restrictions on who can furnish services and in which facilities.[3] Plans may decline to provide or pay for services in some circumstances when procedural rules are not followed by enrollees or providers. Disputes involving these rules tend to be retroactive (i.e., after the rules were allegedly broken and the service was delivered).

Emergency and Out-of-Area Urgent Care. Health plans must pay for or provide care needed in an emergency under an exception to the usual in-plan and prior authorization requirements. Disputes may arise when plans deny that a particular episode qualified as an emergency. The definition of emergency is central in resolving such disputes and for guiding beneficiaries and plans. In the Commission's view, a prudent layperson's perspective should be considered as one of the factors in determining when a health plan should pay for initial screening and stabilization, if necessary, in an emergency.

HCFA regulations define emergency care as services that are needed immediately because of an injury or sudden illness, and the time required to reach the plan's providers would pose a risk of permanent damage to the patient's health (42 C.F.R. 417.401). This definition raises two important issues. One is that the determination should be based on what is known by the patient at the time emergency care is sought, rather than on what is later learned as a result of the emergency department visit. Otherwise, patients could be placed in the position of having to anticipate the outcome of medical diagnosis before seeking care. Another potential problem is that emergency care is sometimes legitimately needed to relieve pain and suffering, but these symptoms may not strictly satisfy Medicare's requirement of a risk of permanent damage to the patient's health.

To respond to these issues, HCFA has instructed health plans that emergency services must be, or appear to be, needed immediately. The determination must be based on the circumstances at the time of the emergency rather than what was revealed later by medical attention (HMO/CMP Manual, Section 2104.1) (HCFA 1992). The agency believes these instructions and its appeals process ensure that the patient's perspective at the time is taken into account (Stieber 1996). In March 1995, HCFA responded to complaints about access to emergency care by reminding health plans of its instructions on this topic (Operational Policy Letter 95-5) (HCFA 1995).

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[3] There is interest in how fee-for-service Medicare can make better use of managed-care tools (see Chapter 11).

Several states have adopted the prudent layperson standard for coverage of emergency care (Bender 1995). This standard evaluates the decision to seek emergency care in light of the perceptions, knowledge, and actions that would be expected of a typical reasonable layperson. Apparently, NDG already applies criteria that approach the prudent layperson standard (Bender 1995; Welch 1996). Federal legislation has been proposed that would make this a statutory requirement (H.R. 2011).[4] Others believe that a regulatory definition would be preferable to a statutory one because it could be revised more easily to meet changing needs. Concern has been expressed, however, that the prudent layperson standard might be used to require payment for all services provided in an emergency department visit. The prudent layperson standard concerns the patient's decision to seek emergency care, so it should govern payment for the initial screening and, if necessary, stabilization of a patient's condition that federal law requires emergency departments to provide to all patients. Additional evaluation and treatment services would be provided consequent to a medical professional's screening, so a different standard should apply to coverage for such services. Consequently, although the Commission endorses the prudent layperson standard for Medicare, the standard should determine coverage only for an initial emergency department screening and stabilization, if necessary.

Health plans, out-of-plan providers, and enrollees can disagree on when care becomes nonemergent, at which time the plan's usual controls over utilization should take effect. After a patient's condition has been stabilized, health plans may attempt to assume responsibility for care by transferring the patient to their own facilities. HCFA should continue to refine its policies so that they reasonably accommodate health plans' needs to manage care once it becomes possible to do so, and are clear to beneficiaries, health plans, and out-of-plan providers.[5]

Similar issues can arise from out-of-area urgent care. HCFA defines urgently needed out-of-area care as "Medicare-covered services required in order to prevent a serious deterioration of an enrollee's health that results from an unforeseen illness or injury" (HMO/CMP Manual, Section 2105). This requires an assessment of the risk of a serious deterioration in health, and does not explicitly include pain and suffering. Disagreements similar to those for emergency care may arise related to lack of prior authorization for hospitalizations and subsequent followup care. Out-of-area urgent care is particularly dispute-prone, and the cost per claim is the greatest of the categories of claims that are reconsidered by NDG (Richardson et al. 1993).

For both emergency care and out-of-area urgent care, the appropriate role for health plans' educational systems and telephone advice lines in determining coverage deserves further thought. Although health plan's advice to enrollees should not necessarily be controlling, the information provided may be considered in applying the prudent layperson standard.

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[4] Although the prudent layperson standard was proposed by the Senate, the conference agreement uses a definition similar to HCFA's current regulation, except that the risk of "permanent" damage to the patient's health is replaced by the risk of "serious" damage to the patient's health.

[5] The Senate proposed to require managed-care plans to respond within 30 minutes to a request for authorization of additional non emergency treatment after the initial evaluation and stabilization, but this provision was not included in the conference agreement.

Access to Special Expertise. Health plans and patients sometimes disagree on when the patient should be referred to a specialist within the plan for diagnosis or treatment. A similar issue arises when plans lack the internal expertise or resources to provide some services in an optimal or efficient manner. Some plans have contracted with other providers or facilities to furnish these services, which effectively make them part of the plan. Some rare or difficult conditions, though, may not be anticipated by such contractual arrangements. It is not clear when plans should be required to pay for treatment by an expert or facility outside of the plan. In California, for example, a managed-care organization was fined by state regulators for requiring that a nine-year-old patient be treated by an in-plan surgeon rather than the out-of-plan pediatric surgical specialist preferred by her family (Morain 1995). There must be a clear medical justification for requiring a plan to pay for out-of-plan care, or the ability of the plan to manage care would be compromised. But there are no formal guidelines to determine when out-of-plan treatment is justified in these kinds of situations and how it should be paid for. Similar issues may apply when access to in-plan expertise is denied.

THE APPEALS PROCESS

An appeals process can be invoked when a health plan declines to provide or pay for a service that a beneficiary believes to be covered under Medicare (HCFA 1994).[6] Any decision by a plan physician or plan representative that a service is not covered or is not necessary can be appealed.[7] Plans may deny post-service claims or pre-service requests for coverage for four types of reasons:

- The service is not medically necessary or appropriate.
- The beneficiary did not follow the plan's administrative rules, such as gatekeeper or in-plan requirements.
- The service is not in the plan's benefit package or exceeds the quantitative limits contained in the package.
- The beneficiary was not enrolled in the plan on the date in question.

The consequences of these denials can be important to beneficiaries. For post-service denials, beneficiaries may be liable to pay for the care unless it was furnished by a provider who has agreed contractually with the health plan to hold the patient harmless in such circumstances. Further, beneficiaries liable for denied claims do not have the protection of any charge limitations. A pre-service denial may preclude beneficiaries from receiving needed medical services. Consequently,

[6] The appeals process is distinct from the so-called internal grievance process required of health plans. The grievance process deals with beneficiaries' complaints about waiting times, physician behavior and demeanor, adequacy of facilities, and other problems that do not involve the failure to provide or pay for medical services.

[7] Some health plans offer a point-of-service benefit that permits services to be obtained out of network for higher cost sharing. Coverage and payment disputes involving the out-of-network services can also be appealed through the Medicare appeals process.

federal law gives beneficiaries the right to appeal such decisions free of charge. Out-of-plan physicians, suppliers, and institutional providers such as hospitals and nursing facilities can represent a beneficiary in an appeal (or file an appeal themselves) under certain conditions. HCFA does not require that in-plan physicians, suppliers, and institutional providers be able to appeal, but some plans permit it.

There is no exactly analogous appeals process in fee-for-service Medicare. Claims for services rendered are submitted to Medicare carriers and fiscal intermediaries by providers and institutions. They may contest claims denials. Fee-for-service beneficiaries are generally not liable for payment when claims are denied.[8]

Elements of the Appeals Process

HCFA regulations prescribe a detailed set of steps that must be followed for appeals (Figure 8-1). When a health plan declines to provide or pay for a service requested by a patient, the plan must give the patient a written "initial determination" documenting its refusal and the reasons for its decision. The plan must also inform the beneficiary of his or her right to a "reconsideration" (i.e., appeal) of that determination. When a reconsideration is requested, the plan must review the initial determination and evidence provided by any party. The reconsideration must be conducted by persons who were not involved in making the initial determination. If the reconsideration does not result in a decision completely favorable to the beneficiary, the entire case file must be forwarded to a HCFA contractor—Network Design Group—for review.

NDG employs nurse case managers supported by physicians, lawyers, and other professionals when necessary.[9] If NDG reverses a health plan's decision, the plan must provide or pay for the service. Such a reversal cannot be appealed by the health plan.[10] If NDG upholds the plan's denial of service or payment, the beneficiary can appeal further to a Social Security Administration (SSA) administrative law judge, then to a Social Security Administration Appeals Council, and then (in cases involving more than $1,000) to a U.S. district court.

Internal Appeals. Little has been published about the operation of appeals processes within health plans. A variety of arrangements appear to be used, often in conformance with state regulation or standards established by external agencies such as the National Committee for Quality Assurance and the Joint Commission on the Accreditation of Healthcare Organizations. One large health maintenance organization, for example, maintains a standing committee to review all appeals. The committee comprises physicians, billing personnel, and other staff knowledgeable about coverage rules. Other

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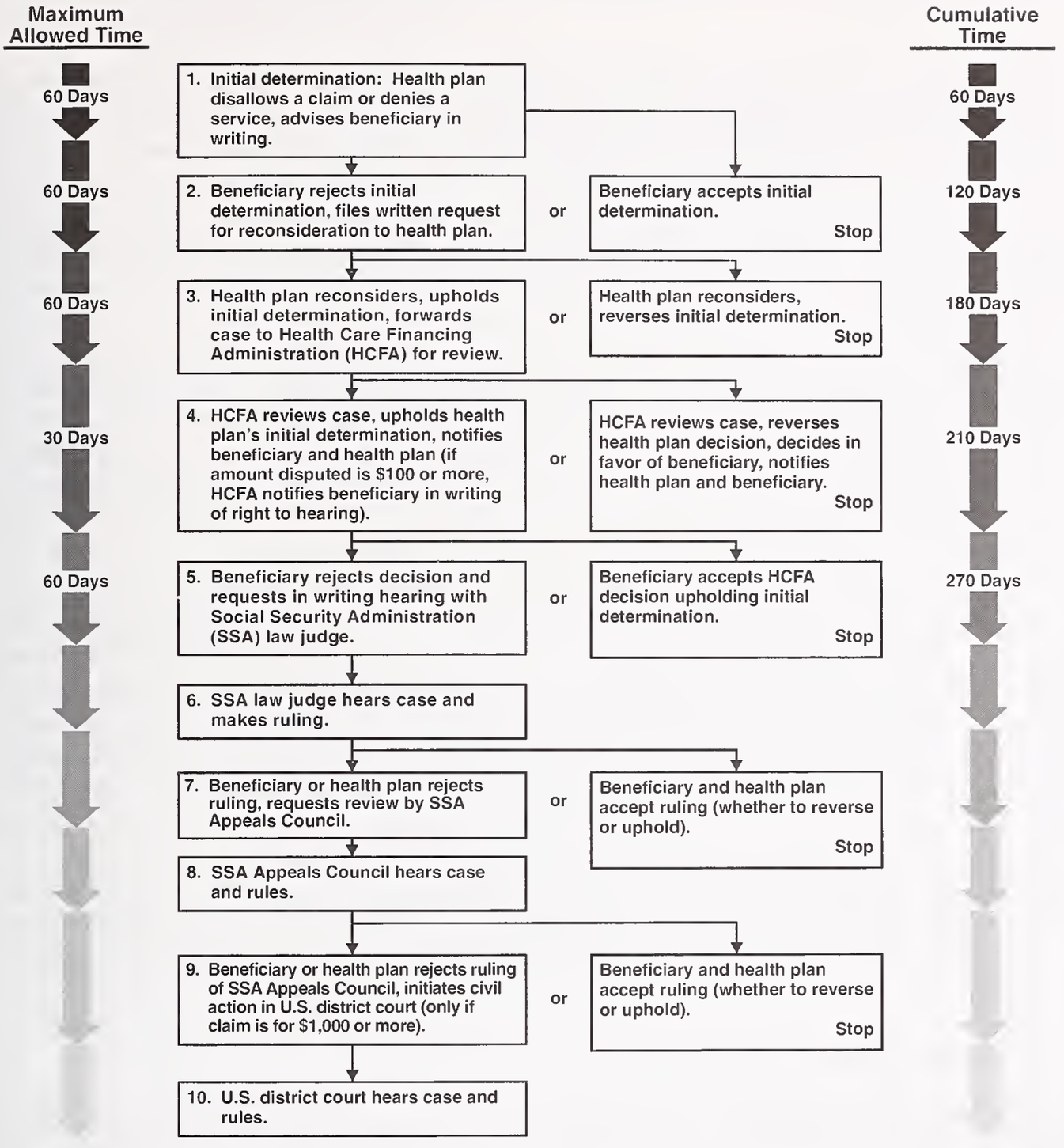
[8] The exception is if the beneficiary signed a written waiver of liability protection acknowledging that the service is not covered by Medicare.

[9] The conference agreement would require that any denials based on medical necessity be reviewed by a physician.

[10] Some plans would like the ability to appeal decisions by NDG that they strongly believe to be incorrect (Welch 1996).

Figure 8-1. Medicare Appeals Process



SOURCE: General Accounting Office 1995.

health plans may use just one person. Some health plans may delegate decisions on some appeals to the medical group that refused the service, which in turn may need to refer the appeal to outside consultants. The total number of appeals filed and their nature and disposition are unknown, although individual plans may keep these statistics. Some initial determinations may be completely reversed by

health plans as a result of internal reconsideration; the number of such reversals is unknown to HCFA because these cases do not proceed further through the system. The rest go through the external reconsideration process.

External Reconsideration. A study conducted by Network Design Group using its case files sheds some light on the external reconsideration process (Richardson et al. 1993). Between 1989 and 1992, the number of reconsideration disputes climbed from 1,688 to 3,700 cases. This represented an increase from 1.7 to 2.2 reconsiderations per 1,000 Medicare managed-care enrollees. The average value of services in dispute between 1989 and 1992 was $2,753, a figure that had risen to $4,300 by 1994. About 40 percent of health plans' service denials between 1989 and 1992 were reversed by NDG, requiring the health plans to pay an additional $7.8 million. In the denials upheld by NDG, beneficiaries were left liable for more than $11 million in claims.

Reconsideration appeals can reflect serious discontent or misunderstanding on the part of the enrollee. NDG analyzed a random sample of 747 of its case files from 1991 (Richardson et al. 1993). Ten percent of the disputes occurred within the first 90 days of enrollment in a Medicare managed-care plan and one-third occurred within the first year. One-quarter of those whose appeals went to NDG for reconsideration disenrolled from their plan within 90 days of the contested service, and a total of 40 percent had disenrolled within two years.

In about 6 percent of disputes, HCFA retroactively disenrolls the beneficiary from the plan. This means that the beneficiary is effectively deemed never to have enrolled, and the services that were delivered are eligible for payment on a fee-for-service basis by Medicare. Retroactive disenrollment can occur when there is a complete breakdown in the enrollee's understanding of or compliance with managed care. In other instances, beneficiaries deny that they ever knowingly enrolled in the health plan. Retroactive disenrollment may be ordered as a remedy for alleged marketing abuses by health plans.

In NDG's study of reconsideration cases in 1991, most of the disputes involved post-service denials, i.e., claims for payment after the care was given (Richardson et al. 1993). In the past two years, however, 40 percent of reconsideration cases involved pre-service denials (Richardson 1995b). NDG expects this trend to continue.

Areas for Improvement in the Appeals Process

HCFA and others have identified several areas for improvement in the current appeals process. These include:

- the timeliness of the process, especially for pre-service denials,
- beneficiaries' understanding of the process, and
- HCFA's monitoring and oversight of the plans.

HCFA has announced a new effort, termed the "Managed Care Appeals and Grievances Initiative," to address these topics.[11] The initiative is currently in its planning stages, so the Commission intends to monitor its development and implementation.

Improving the Timeliness of the Appeals Process. The length of time it takes to resolve some cases has been called the most important process issue for appeals (Bender 1995). Delays stem from two causes: lack of compliance with existing time limits, and the need to resolve some urgent cases sooner than the current deadlines would require.

Considerable delays are built into the appeals process. Even with all deadlines met, seven months can pass between an initial denial by a health plan and a decision by NDG. An additional 30 days may pass if NDG needs to obtain more information from the plan. Compliance with the required deadlines is inconsistent. HCFA has found that some health plans in California and Florida inappropriately retained appeals for two to three times longer than the allowed 60 days, on average, before forwarding them to NDG, although some improvement has been noted anecdotally in California (GAO 1995; Dallek 1995b). Some delays are caused by the need to obtain records from out-of-plan providers, over whom the health plan has no leverage to obtain compliance.

The second area of concern about timeliness is pre-service denials in which the perceived need for the service is more acute than the time periods built into the appeals process.[12] NDG has been attempting to accelerate review of urgent pre-service cases. HCFA is working on how to require expedited decisions for such cases. The conference agreement passed by the Congress in November 1995 (H.R. 2491) would require appeals in life-threatening, emergency, or urgent cases to be decided on an expedited basis, depending on the urgency of the particular situation, by an independent outside entity under contract with HCFA.

An existing expedited review regulation gives health plan enrollees the right to request immediate peer review organization (PRO) review of their health plan's decision not to cover additional days in the hospital. If beneficiaries disagree with the discontinuation of coverage, they are to be given a written notice of noncoverage and an explanation of the procedure for obtaining immediate PRO review of the decision. The PRO must respond within one working day. This immediate PRO review process

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[11] The objectives of the initiative are to (1) develop policies that are oriented to the needs of beneficiaries and understandable by all; (2) expedite the appeals process for certain time-sensitive situations; (3) meet the information needs of current and potential Medicare managed-care enrollees regarding their appeal rights; (4) develop and improve HCFA's data systems on appeals and grievances to better manage appeals information, improve program oversight and accelerate it where necessary, and provide timely, understandable customer information; and (5) provide effective feedback on appeals to plans and refined mechanisms for monitoring, thereby assisting in the continuous improvement of health plan performance (Fried 1995).

[12] Currently, one safety valve is that, on a monthly basis, beneficiaries can disenroll and return to fee-for-service Medicare to try to obtain services precluded by their health plan. This option is useful only when disenrollment can be effected before the services are needed. Plans benefit from stable enrollments, however, so disenrollment may be permitted less frequently after reform. This would make disenrollment less useful as a safety valve.

precludes use of the standard appeals process. The system is still too new to permit evaluation of its effectiveness and cost.[13]

An expedited review procedure has costs. Conducting a review within a short time can be burdensome to health plans and reviewers. The decisionmaker must possess expertise in the relevant medical fields and be provided with detailed clinical information about the particular case. Even so, a remote reviewer will never be in a position to judge the situation as well as the patient's treating physician. It is also not clear how to determine which claims qualify for accelerated review. The clinical need of the patient—rather than arbitrary time limits—should dictate the speed of a pre-service review, but this may be difficult to put into practice. Ideally, plans should be accountable to HCFA and the public for the operation of their internal appeals processes, so that the need for external review would be infrequent. In light of these potential problems, an expedited review process must be carefully designed and its effectiveness and cost assessed after it is instituted.

Educating and Empowering Beneficiaries. To receive the full benefits of the right to appeal, beneficiaries need to understand the process and when to invoke it. A recent study found that 25 percent of enrollees were not aware of their right to appeal denials of service (Loen 1996). This problem seems remediable with stronger educational efforts by both HCFA and plans.

A more difficult problem is the asymmetry of knowledge between health plan and patient that is an inherent part of medicine. Sometimes it is clear that care is being withheld or denied, such as when ongoing care is curtailed (e.g., physical therapy or nursing home care). But even when beneficiaries file an appeal, they often do not provide evidence to support their cases (Richardson et al. 1993). Beneficiary advocates inside or outside the plan could help them draft appeals. In other circumstances, beneficiaries may be unaware that a service was effectively being denied. In situations that involve a choice among alternate approaches to care, for example, the beneficiary may not be aware that alternatives exist. The role of physicians in educating their patients and advocating on their behalf is a salient issue. Many believe that physicians should not be restricted from discussing alternate approaches to care with their patients (Todd 1996; Corry 1996). Health plans should inform beneficiaries and their physicians of the basis for denials.

Enhancing HCFA's Monitoring and Oversight. Advocacy groups cite lack of compliance with existing HCFA regulations, illustrated by the problems described above, as a longstanding problem (Dallek 1995a). The General Accounting Office recently concluded that HCFA has not adequately developed and staffed efforts to monitor plans' compliance with various regulations to protect beneficiaries' interests, including those related to the appeals process (GAO 1995). Some plans have not consistently complied with the time limits built into the appeals process. NDG was able to resolve only 38 percent of its cases in 1993 within the goal of 30-day goal set by its contract with HCFA, although it has reportedly improved its performance since then (GAO 1995). One beneficiary group contends that

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[13] The same 24-hour immediate review process has been available to fee-for-service Medicare beneficiaries for several years. In the 12 months ending June 30, 1995, PROs reported 2,301 requests for immediate review of impending noncoverage of additional hospital days. Only 12 percent of these were decided in favor of the beneficiary, and in some of these the additional length of stay covered may have been minimal (Donahue 1996).

greater use of substantial fines and other punitive measures would improve plans' compliance dramatically (Dallek 1995a). HCFA thinks it has substantially improved its monitoring and oversight activities, and disagrees that the lack of use of civil monetary penalties constitutes weak enforcement (GAO 1995). The agency also plans to perform routine monitoring of plans' compliance with regulations every year instead of biannually (Miller 1996).

HCFA should hold health plans accountable for the operation of their internal appeals processes. This includes collecting data on the number of appeals filed and the outcomes of each stage of the process. The agency is considering, as part of its new initiative, how best to do this and produce comparative reports. The reports should provide beneficiaries with useful information when choosing among plans and give health plans feedback that can help them improve their performance. Competition would then favor health plans that perform well.

Alternatives to HCFA's Formal Appeals Process

The importance of the availability of the external appeals process is underscored by the proportion of coverage denials that are reversed by NDG. Still, it would be undesirable for every disagreement to trigger an elaborate administrative proceeding. The appeals process is slow, complex, relatively expensive, and may not always prove satisfactory to beneficiaries or plans. Some of the disputes that traverse the full reconsideration process are for relatively small amounts, less than $100. The cost of resolving these claims far exceeds the cost of the claims themselves. Even within the appeals system, some way of triaging disagreements may need to be devised.

A more fruitful avenue, in the Commission's view, may lie in developing better systems within plans to prevent disagreements and to identify and resolve those that occur in a manner that is satisfactory to both health plans and patients. It is clearly in the interest of health plans and beneficiaries alike to prevent disputes. Greater patient and provider education, second opinions, systems to help enrollees follow managed-care rules, and other methods might help.

For the disputes that still arise, alternative means of resolving them at the level of health plans might be tried. This could include the use of medical ombudsmen, mediation, outside professional review organizations, and other techniques. For pre-service denials, these alternatives should operate within the time periods required by the patient's condition. HCFA should encourage health plans to develop and test alternatives that could forestall use of the formal appeals process.[14] Current law may discourage alternative modes of problem solving. When a plan becomes aware of a beneficiary's complaint about nonservice, the formal appeals process must be set in motion with a written notice to the beneficiary.

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[14] The relationship between federal and state regulation needs to be considered. It would be undesirable for duplicate processes to be required. A few states have established strong consumer protections that apply to all health maintenance organizations (Dallek et al. 1995). California, for example, has enacted new laws to strengthen state oversight and monitoring of managed-care plans and to make information about the plans publicly available. It has implemented new grievance rules including expedited review provisions and a new state hotline number for consumer complaints.

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Medicare Fee-for-Service Physician Payment

As the transition from charge-based physician payment to the Medicare Fee Schedule enters its final year, patterns in payments to physicians continue to evolve and fee schedule payment policies are undergoing improvement and refinement. Payment under the fee schedule is determined primarily by two elements: relative value units (RVUs), which reflect the relative resource demands of services, and conversion factors, which translate relative values into dollar payment amounts. Relative payments across services are not determined exclusively by the relative value units, as originally envisioned, because a different conversion factor is currently used for each of three groups of services. As a result, the change in relative payments to physicians of different specialties under the fee schedule has been smaller than originally expected. Anticipated policy modifications, such as implementation of resource-based practice expense relative values in 1998, will continue to change the relative distribution of payments even after the transition to the fee schedule is complete.

This chapter includes:

- *Analyses of physician payment patterns in 1995*
- *Issues surrounding introduction of resource-based practice expense relative values*
- *Update on the five-year review of work relative values*
- *Analysis of payment areas*
- *Strategies for implementing payment policy changes*
- *Changes to payment policies for investigational devices*

Recommendations

Several implementation policies should be adopted to maintain the integrity of the fee schedule, consistent with the framework designed by the Commission in 1994:

- *Implementation of any changes to work relative values as a result of the current five-year review should be budget neutral with respect to work values and should not affect practice expense and malpractice expense relative values.*
- *The Health Care Financing Administration should continue to achieve overall budget neutrality by*

adjusting the conversion factors as it did for 1996, rather than by adjusting relative values, as it has in previous years.

- *The relationship between the three components of the fee schedule should be rebased annually to reflect the three-year moving average of physician revenue shares as reported in national surveys.*

The Congress should revise current law so that resource-based practice expense relative values will be phased in over a three-year period beginning in 1998. In addition, the Health Care Financing Administration should be directed to develop a process and timetable for refinement of resource-based practice expense relative values, which should be announced when proposed values are released for public comment.

The Congress should revise current law so that the malpractice expense component of the Medicare Fee Schedule will be resource-based. New malpractice expense relative values should be phased in over a few years. The Health Care Financing Administration should be directed to collect data on risk groups and relative insurance premiums across insurers that can be used to develop new malpractice expense relative values.

Fee schedule payment areas should be defined on a consistent basis nationwide. Area boundaries should be reanalyzed periodically and revised to reflect significant changes in within-area input price homogeneity and across-area price heterogeneity. Any metropolitan area that crosses state borders should have uniform geographic practice cost index values and be treated as if it falls entirely within the state with the largest share of its population.

For devices subject to Food and Drug Administration approval, and for other services that the Health Care Financing Administration has not approved for coverage, Medicare should pay up to the cost of standard care when the device or service is clearly substituting for an established one and is being evaluated in a Food and Drug Administration or other federally approved study.

The chapter begins by briefly reviewing the distribution of Medicare physician payments in the first half of 1995. Payments are analyzed by type of service, location, and physician specialty and then examined with regard to the three components of the fee schedule—physician work, practice expense, and malpractice expense. The second part of the chapter describes ongoing policy developments, including activities under way to develop resource-based practice expense relative values, the five-year review of work relative values, a recent analysis of payment areas funded by the Health Care Financing Administration (HCFA),

and strategies for implementing payment policy changes. Finally, recent modifications to payment policies for investigational devices are discussed.

Most proposals to reform the Medicare program have included provisions for adopting a single conversion factor, a major policy change that the Commission has recommended for several years. Chapter 10 of this report discusses this issue in detail.

DISTRIBUTION OF MEDICARE PHYSICIAN PAYMENTS

During the transition to the fee schedule, actual physician payments were determined by a blend of historical payment levels and fee schedule amounts. The pattern of payments, therefore, has been different from that which will occur now that payments are based solely on the fee schedule. Throughout the transition period, the Commission has analyzed the effect of policy changes on actual payments, which reflect the blended payment amount, and simulated payments, which represent payment under a fully implemented fee schedule. These two different types of analyses help policymakers understand actual payment patterns and identify the likely effect of new fee schedule policies on payments. This section describes changes in the distribution of physician payments between 1994 and 1995 and then analyzes the share of payments attributable to each of the three fee schedule components.

Changes in Physician Payment Patterns Between 1994 and 1995

The policy sources of change in the distribution of physician payments between 1994 and 1995 include:

- the continued transition to the fee schedule, so that a larger share of payments is based on the fee schedule instead of historical levels;
- changes in relative value units;
- changes in the three conversion factors; and
- implementation of the revised geographic practice cost indexes (GPCIs).

Based on previous simulations of a fully implemented fee schedule, the transition was expected to lead to increases in payments to primary care specialties relative to subspecialties. Similarly, evaluation and management services were expected to gain relative to procedures and surgical services. While these changes have occurred, they have been smaller than anticipated because of the continued use of three separate conversion factors, with that for surgical services resulting in the highest payment per relative value unit (PPRC 1994; PPRC 1995a).

Medicare claims data from the first six months of 1994 and 1995 were analyzed to measure changes in physician payment patterns. These data, which represent a 5 percent sample of beneficiaries, were used to describe the pattern of payments and to analyze the sources of payment changes.

Across all services, Medicare payment per service went up 3.8 percent, on average, between 1994 and 1995 (Table 9-1). This increase, combined with a 4.1 percent rise in volume and intensity of services per physician, drove up Medicare payment per physician by 8.0 percent. Medicare revenue per physician, made up of Medicare payments on all claims and balance billing on unassigned claims up to charge limits, increased by 7.9 percent. Growth in revenue per physician was slightly lower than growth in payment per physician because of declines in balance billing (PPRC 1995b).

There are marked differences in payment changes across service families and physician specialties. The 9.0 percent rise in payment per service for primary care was higher than the increase for all other types of services (Table 9-1). Payment levels for evaluation and management services other than primary care went up by 6.7 percent and those for surgical services increased by 5.0 percent, while payment rates for other nonsurgical services fell by 0.4 percent.

Changes in payment per service by specialty reflect the mix of services each specialty actually provided. For example, family and general practice physicians, who furnish a large share of primary care services, experienced one of the largest average service payment growth rates, at 7.5 percent (Table 9-1). Except for ophthalmologists, surgeons also received payment increases of 5.2 percent or more. Specialists, such as cardiologists and gastroenterologists, who provide a relatively large share of other nonsurgical services saw little growth in payment levels; in fact, average payment levels actually fell by 1.4 percent for cardiologists.

Payment levels grew faster in rural than in metropolitan areas (Table 9-1). They went up by 4.8 percent to 6.6 percent in rural areas, but only 3.5 percent to 3.8 percent in metropolitan areas. These patterns are consistent with the Medicare Fee Schedule's expected shift of payments toward rural areas.

Changes in volume and intensity do not appear to be highly correlated with those in payment levels, either by service type or physician specialty. Most specialties had increases in the volume and intensity of services per physician as well as in total payments and revenue per physician (Table 9-1). One exception was radiologists, among whom volume and intensity per physician decreased by 1.5 percent, mostly in the area of routine diagnostic radiology services. Gastroenterologists also had decreases in volume and intensity per physician, as well as in Medicare payments and revenue. This was due largely to reductions in volume and intensity of colorectal endoscopy procedures like sigmoidoscopy.

The fact that primary care services had the highest payment growth may appear surprising, given that these services received a 7.9 percent conversion factor update in 1995, whereas surgical services got a 12.2 percent update. To analyze the effects of policy changes on Medicare payment per service, changes in payment rates were separated into those caused by changes in, respectively, relative value units, geographic adjustment factors (GAF), and conversion factors (Table 9-2). Changes not explained by these three policy elements are the result of the transition from historical to fee schedule payments, which is difficult to measure explicitly. Payment increases due to high conversion factor updates for surgical services were offset somewhat by the continued transition away from historical payment levels to fee schedule amounts. Primary care services, on the other hand, realized payment increases from both the conversion factor update and ongoing transition, and so had higher net growth than surgical services.

Table 9-1. Change in Medicare Payment and Volume, by Type of Service, Location, and Specialty, 1994-1995 (percentage)

Type of Service, Location, and Specialty	Medicare Payment per Service	Volume and Intensity per Physician	Medicare Payment per Physician[a]	Medicare Revenue per Physician[b]	Percentage of 1995 Medicare Payments
All Services	3.8%	4.1%	8.0%	7.9%	100.0%
Evaluation and Management Services					
Primary care	9.0	3.1	12.4	12.2	20.0
Other	6.7	0.3	6.9	6.9	16.5
Surgical Services	5.0	4.5	9.7	9.6	23.2
Other Nonsurgical Services	-0.4	5.9	5.4	5.4	40.3
Location					
Metropolitan areas					
>1 million	3.5	2.8	6.4	6.4	53.0
<1 million	3.8	5.6	9.6	9.5	34.5
Rural counties					
>25,000	4.8	7.1	12.2	12.1	10.1
<25,000	6.6	1.4	8.1	7.9	2.5
Specialty					
Cardiology	-1.4	3.5	2.1	2.0	8.4
Family/general practice	7.5	-0.1	7.4	7.2	10.1
Gastroenterology	1.2	-2.6	-1.5	-1.6	2.9
Internal medicine	5.0	5.1	10.4	10.2	16.7
Other medical specialties	5.7	8.0	14.2	14.2	8.2
General surgery	6.1	7.5	14.1	14.0	5.6
Dermatology	7.8	4.2	12.3	12.1	2.1
Ophthalmology	1.1	2.2	3.4	3.3	9.0
Orthopedic surgery	5.7	3.8	9.7	9.5	4.8
Thoracic surgery	5.2	4.2	9.6	9.5	2.4
Urology	5.9	5.8	12.0	11.9	4.1
Other surgical	5.8	2.4	8.3	8.2	3.2
Radiology	1.6	-1.5	0.1	0.0	7.9
Pathology	-1.6	2.3	0.7	0.6	1.2
Other	2.5	4.8	7.4	7.5	13.4

SOURCE: Physician Payment Review Commission analysis of 1994-1995 Medicare claims, 5 percent sample of beneficiaries; American Medical Association 1994 and 1996.

[a] Medicare payments are allowed charges.

[b] Medicare revenue is allowed charges on assigned claims and submitted charges on unassigned claims not in excess of charge limits.

Predictably, 1995 conversion factor updates had the largest effects of any policy change on payment per service for all services (Table 9-2). The updates ranged from a high of 12.2 percent for surgical services to 7.9 percent for primary care and 5.2 percent for other services.

Table 9-2. Effect of Policy Changes on Fee Schedule Payments, 1994-1995 (percentage)

Type of Service, Location, and Specialty	Total Change in Medicare Payment per Service	Change Due to: Relative Value Unit Changes	Change Due to: Geographic Adjustment Factor Changes	Change Due to: Conversion Factor Updates	Change Due to: Transition to Fee Schedule
All Services	3.8%	-1.9%	0.1%	7.5%	-1.9%
Evaluation and Management Services					
Primary care	9.0	-1.0	0.0	7.9	2.1
Other	6.7	-1.0	0.0	5.2	2.5
Surgical Services	5.0	-3.7	0.0	12.2	-3.5
Other Nonsurgical Services	-0.4	-1.6	0.1	5.2	-4.1
Location					
Metropolitan areas					
>1 million	3.5	-1.8	0.1	7.4	-2.2
<1 million	3.8	-2.0	0.1	7.7	-2.0
Rural counties					
>25,000	4.8	-1.9	-0.2	7.7	-0.8
<25,000	6.6	-1.4	-0.3	7.4	0.9
Specialty					
Cardiology	-1.4	-2.6	0.0	5.7	-4.5
Family/general practice	7.5	-1.1	-0.1	7.2	1.5
Gastroenterology	1.2	-1.9	0.1	5.7	-2.7
Internal medicine	5.0	-1.1	0.1	6.4	-0.4
Other medical	5.7	-1.0	0.1	5.6	1.0
General surgery	6.1	-1.4	0.0	9.9	-2.4
Dermatology	7.8	-1.0	0.1	10.5	-1.8
Ophthalmology	1.1	-5.7	0.1	10.0	-3.3
Orthopedic surgery	5.7	-3.0	0.0	10.5	-1.8
Thoracic surgery	5.2	-1.4	0.0	11.2	-4.6
Urology	5.9	-1.2	0.1	10.1	-3.1
Other surgical	5.8	-2.0	0.1	10.0	-2.3
Radiology	1.6	-1.0	0.0	5.3	-4.8
Pathology	-1.6	-1.6	0.1	5.2	-5.3
Other	2.5	-0.8	0.1	7.3	-4.1

SOURCE: Physician Payment Review Commission analysis of 1994-1995 claims, 5 percent sample of beneficiaries.

NOTE: Changes due to the transition to fee-schedule based payments are calculated as the difference between total payment changes and the sum of changes attributable to relative value changes, geographic adjustment factor changes, and conversion factor updates.

Relative value unit changes dampened the effects of the conversion factor updates (Table 9-2). An across-the-board reduction of 1.1 percent was made to all RVUs to offset the effect of fee schedule and other payment policy changes on total expenditures. Practice expense RVU adjustments were also made, as required by the Omnibus Budget Reconciliation Act of 1993 (OBRA93). The resulting RVU changes for 1995 ranged from –1.0 percent for primary care to –3.7 percent for surgical services.

Geographic adjustment factor changes were intended to be budget neutral overall and were, in fact, quite small (Table 9-2).[1] These changes were primarily due to the use of more current information in computing the geographic practice cost indexes that make up the GAFs for Medicare payment localities, along with some technical improvements in the calculation of the GPCIs. The updates appear to have reduced rural area GAFs by 0.2 percent to 0.3 percent, on average. Similar-sized changes will occur in 1996 when the new GAFs are phased in completely.

Residual changes affecting Medicare payment per service varied from 2.5 percent for evaluation and management services other than primary care to –4.1 percent for other nonsurgical services (Table 9-2). These changes reflect the continued transition away from the customary, prevailing, and reasonable (CPR) charge system to fee schedule payments. The final year in which CPR policies affected payments was 1995. Starting in 1996, payments will be based entirely on the fee schedule. Compared with others, medical specialties generally experienced smaller transition effects in 1995. By contrast, the combination of transition effects and RVU changes, along with relatively low conversion factor updates, led to reductions in average payment per service for cardiologists and pathologists of 1.4 percent and 1.6 percent, respectively.

Calibrating the Three Components of the Fee Schedule

The work, practice expense, and malpractice expense components of the fee schedule originally were calibrated relative to one another so that, given expected service volumes, Medicare payment shares would correspond to reported physician practice revenue shares. As it finalized the original fee schedule in 1991, HCFA used information from an American Medical Association (AMA) 1989 survey about practice revenue shares. The survey found that 54.2 percent of physician revenues went to physician net income (physician work), 41.0 percent to practice expenses, and 4.8 percent to malpractice expenses. Therefore, the three components were based relative to one another so that, given expected service volumes, they would account for these same shares of Medicare payments (HCFA 1991). If either physician revenue shares or Medicare service mix change much over time, then Medicare payment shares will no longer match reported revenue shares. To maintain this relationship, the components of the fee schedule may have to be rebased relative to one another periodically.

The Commission has previously expressed concern about implementing policies that distort the relationship among the fee schedule's three components (PPRC 1994; PPRC 1995). It has argued that fee schedule changes should only affect the relative composition of payments based on data about how the components should relate to one another. Implementation of policies based on other considerations can inappropriately change the relative composition of payments. When the OBRA93 reductions to overvalued practice expense values were put in place, for example, the Commission was concerned that the overall share of payments due to practice expenses was reduced rather than reallocated across services.

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[1] Budget-neutral 1995 GAF estimates were adjusted slightly to ensure that payment policy changes were budget neutral overall. Based on claims data, weighting of the 1995 GAF changes with allowed charges in each Medicare payment locality produces an average GAF change for all services of just over zero, at 0.1 percent.

To study change in reported physician revenue shares over time, a consistent set of revenue shares was calculated from data available in AMA reports between 1990 and 1994 (Table 9-3). Three-year moving averages help to smooth over annual fluctuations and identify whether there are any underlying trends (Table 9-4). Even though the annual data are relatively volatile, the moving average suggests a slight drop in share of revenues devoted to net income and malpractice expense, with an offsetting increase in the practice expense share.

Table 9-3. Annual Mean Expenses as a Percentage of Mean Total Revenue, by Category, 1989-1993

	Net Income	Practice Expenses	Professional Liability Premiums
1989	54.2%	41.1%	4.8%
1990	55.3	40.4	4.3
1991	53.1	42.7	4.1
1992	53.1	43.4	3.5
1993	54.5	41.9	4.0

SOURCE: American Medical Association 1990-1994.

NOTE: Percentages are calculated as reported mean expenses within each category as a share of reported mean total revenues from each year's survey.

Table 9-4. Three-Year Moving Average of Annual Mean Expenses as a Percentage of Mean Total Revenue, by Category, 1989-1993

Period	Net Income	Practice Expenses	Professional Liability Premiums
1989-1991	54.2%	41.1%	4.4%
1990-1992	53.8	42.2	4.0
1991-1993	53.6	42.7	3.9

SOURCE: American Medical Association 1990-1994.

NOTE: Percentages are calculated as reported mean expenses within each category as a share of reported mean total revenues from each year's survey. Three-year moving average is the average share reported during each three-year period.

Although the changes are fairly modest for each category, in combination they can quickly alter the relationship between net income, practice expenses, and malpractice expenses. For example, the revenue share averages between 1989 and 1991 suggest that practice expenses are about 76 percent of net income, while the 1991-1993 shares move practice expenses to 80 percent of net income. These relative changes are relevant to how components of the fee schedule relate to one another.

Using service volumes from six months of 1995 claims and 1995 fee schedule payment amounts, the share of total Medicare payments attributable to each component of the fee schedule was calculated. These estimates suggest that, had 1995 payments been fully based on the fee schedule, 55.2 percent would have been attributable to the physician work component, 41.0 percent to the practice expense component, and 3.8 percent

to the malpractice component. Considering them relative to one another, practice expense payments are 74 percent of work payments. This is fairly close to the 76 percent target from the 1989 data, but somewhat different from the most recent three-year average figure of 80 percent. Given 1995 service volumes, work relative values would have to be reduced by 2.9 percent for simulated 1995 fee schedule payment shares to match the most current three-year average revenue shares. Similarly, practice expense relative values would be increased by 4.1 percent and malpractice expense relative values by 2.6 percent.

The Commission has concluded that the three components of the fee schedule should be rebased annually to reflect the three-year moving average of revenue shares as reported in national surveys such the AMA's.[2] Although the adjustments estimated above may appear fairly large, they are necessary to compensate for shifts over the several years since the fee schedule was originally created. Subsequent annual adjustments would be much more modest. In fact, if adjustments had been made annually as recommended by the Commission, the 1995 fee schedule would have required a 0.4 percent decrease in work values and a 1.2 percent increase in practice expense values, based on the difference between the 1990-1992 average revenue shares and those from the 1991-1993 period. If revenue shares continue to change at the same rates as they have in past few years, delay in recalibrating the three components will lead to yet larger adjustments. Based on current revenue share trends and 1995 payment shares, a 4 percent reduction in work values, 8.3 percent increase in practice expense values, and 7.9 percent reduction in malpractice values will be necessary in two more years.

PHYSICIAN PAYMENT POLICY DEVELOPMENTS OF 1995

Several Medicare physician policy changes were proposed or implemented in 1995. As required by 1994 technical amendments to the Social Security Act, HCFA took steps toward developing resource-based practice expense relative values in preparation for their implementation in 1998. In addition, the first five-year review of work relative values progressed so that refined values will be available for implementation in 1997. Health Economics Research, Inc. (HER) recently completed analysis of alternative payment area definitions under contract with HCFA. For the first time, HCFA maintained budget neutrality by adjusting the conversion factors rather than relative value units when implementing payment policy changes for 1996.[3] Finally, HCFA has adopted a new payment policy on investigational devices. Each of these developments is discussed below. One other important proposed policy change—adoption of a single conversion factor—is discussed in Chapter 10.

Resource-Based Practice Expense and Malpractice Relative Values

Since the fee schedule was first described in OBRA89, the Commission has considered the current charge-based method for creating practice expense and malpractice relative values as temporary and has since

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[2] Under use of three conversion factors, any such adjustment should be considered when comparing actual volume growth to growth standards under the Volume Performance Standard system.

[3] A minor adjustment of 0.36 percent was necessary to compensate for refinement of relative values, addition of codes to the fee schedule, and other payment policy revisions.

developed resource-based approaches that are more consistent with the goals and intent of the fee schedule (PPRC 1992a; PPRC 1992b; PPRC 1993). Over the past five years, it has held several meetings and a conference on this topic, participated in a HCFA-sponsored conference, conducted a pilot study, issued special research reports for comment, and recommended to the Congress that the fee schedule be revised to include resource-based practice expense and malpractice relative values (PPRC 1993). One of the Congress's final acts in 1994 was passage of technical amendments to the Medicare law that included provisions mandating development and implementation of resource-based practice expense relative values. The Secretary of Health and Human Services is required to devise a methodology that reflects the staff, equipment, and supplies necessary to provide medical and surgical services in various settings and report on this to the Congress by June 30, 1996. This approach will be implemented in 1998, when the current charge-based method is repealed. Although these steps should improve the practice expense component of the fee schedule, the Commission reiterates its earlier recommendation that resource-based malpractice relative values also be developed.[4]

In November 1994, HCFA released a request for proposals (RFP) to develop the database necessary to calculate resource-based practice expense relative values. According to the RFP, HCFA is interested in exploring a variety of approaches to creating relative values and thus asked for proposals to develop a comprehensive database. The agency expects to let additional contracts to support development of several approaches once the database is complete, originally scheduled for spring 1996.

Abt Associates was awarded the contract for the first phase of this study.[5] As described in a briefing paper Abt developed for a meeting of the project's Technical Expert Group (TEG), there are three components to its data collection approach (Abt 1995).[6] First, several thousand medical practices will be surveyed about case mix, practice characteristics, and costs within broad categories. Second, Clinical Practice Expert Panels (CPEP) will be convened to develop profiles of the resources required to provide a set of reference services selected from groups of services thought to be clinically related and to have comparable direct costs. Finally, Abt will compile input price data for direct inputs from a variety of sources.

From these data, Abt will construct a research database and conduct some analyses. In particular, the contractor expects to:

- extrapolate direct costs from reference services to each service in each group or family,
- allocate indirect costs to individual services,

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[4] The Commission has proposed an approach in which the relative risk of services is determined by the increase in professional liability premiums for physicians who perform them. The method and simulated effects of its implementation are described in *Professional Liability Insurance Expenses under the Medicare Fee Schedule: A Resource-based Approach*, No. 92-7.

[5] The contract with Abt includes subcontracts and consulting agreements with a variety of others, including Medical Group Management Association, researchers from the University of Pennsylvania, and EnterMedica Resources.

[6] TEG participants include researchers who have already done work in this area or are likely to be involved in subsequent phases of this project and representatives of several professional societies (American Medical Association, American College of Physicians, American College of Surgeons, American College of Radiologists). TEG meetings have also been attended by observers from the Relative Value Scale Update Committee, American Hospital Association, and the Commission.

- validate cost estimates with a review by the CPEPs, and
- perform an impact analysis.

Those awarded contracts under the second phase of the project will use the Abt database to explore alternative methods for constructing practice expense relative values.

The Commission had proposed an approach to developing resource-based relative values that would require primary data collection of direct costs and rely on the development of allocation techniques for indirect costs. This suggestion reflects typical accounting practices wherein direct costs are measured at the product or service level but indirect costs are allocated to specific services relative to some basis. It concluded from its pilot project that information about direct inputs at the service level could be collected from practices and used to develop direct cost estimates. Expert panels were suggested as a resource for grouping services relative to resource requirements; direct input data would then be collected for reference services within the resulting groups. The Commission also discussed alternative approaches to allocating indirect costs, such as physician time.

The approach adopted by HCFA and its contractor differs from that suggested by the Commission. For example, the Abt practice survey is focused on gathering data that will be used for assigning indirect costs to services, not on collecting direct cost information as the Commission suggested. Instead, the current project will use expert opinion rather than service-level data to develop direct cost profiles for reference services and then extrapolate to others in predefined service families.[7] In the HCFA/Abt approach, the service groups were established before the expert panels were convened to develop cost profiles. Abt established the groups initially based on advice from its clinical consultants and HCFA medical staff. The service groups were revised based on comments from specialty societies and further review by the contractor and HCFA staff.

On the basis of its own experience and the testimony many organizations presented at its annual hearing, the Commission is concerned that it will be difficult for HCFA to develop reliable relative values in time for implementation in 1998 for a variety of reasons. First, both researchers and members of the medical community questioned the feasibility of fielding the proposed survey in a timely manner while still obtaining valid, complete data. They suspect that, because of the complicated nature of the survey, response rates may be low and even willing respondents may have difficulty responding completely and accurately without extensive technical assistance. As a result, the survey phase may take longer than anticipated if the necessary response rates and data quality are to be attained.

Second, the initial schedule was quite ambitious, and activities such as survey clearance by the Office of Management and Budget have already fallen behind target dates. It seems unlikely that the database will be ready when HCFA expects to release an RFP for the analytic phase of the project, so that implementation of this second step is likely to be delayed.

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[7] HCFA/Abt changed the CPEP process to allow specialty societies to provide information about service resource demands for use by panel members in developing these direct cost profiles.

Finally, it is not clear how HCFA plans to develop final values from the estimates produced under the various analysis contracts it expects to award. Even if all activities occur on schedule, HCFA will receive final reports from all analysis contractors some time in mid-1997. Without a well-defined approach to comparing the various results and choosing one, or for integrating them with one another, it is not clear how HCFA staff will be able to issue a proposed rule early enough to receive and analyze comments before issuing a final rule by December 1997.

Delaying implementation may give HCFA more time to develop well-based values, but such a change would be frustrating to those stakeholders who think the current values are perpetuating inequitable payments. These parties argue that even if the new values are imperfect at first, they are likely to represent an improvement over the charge-based values now in place.

There may be ways, short of such a delay, that could help smooth introduction of the relative values in a timely fashion. For example, the Commission's original recommendation to implement resource-based practice expense relative values included a transition period so that the values would be phased in over a few years. The transition was originally recommended because, according to the Commission's analysis, payments for some services would be likely to drop dramatically, raising concerns that such large payment swings implemented overnight would alienate some physicians from providing care to Medicare beneficiaries. This argument is particularly relevant in the current context if a single conversion factor is adopted because payment for some surgical services may be significantly affected by both policy changes. In addition, given concerns about the time available to HCFA to develop values, a transition period may provide some leeway for developing and refining values. Therefore, the Commission is again proposing that a transition period be defined for implementation of the resource-based relative values.

The other step that may lead to better acceptance of the new practice expense values is a well-planned, clearly stated refinement process. Physician acceptance of the physician work relative values seemed to increase as the values were refined over the first few years of the fee schedule, which may be in part because they thought that there was mechanism for addressing the most egregious problems with values. In view of the short time and the concern many stakeholders have already expressed about the process, HCFA should develop a refinement process and schedule that are clearly articulated when the proposed rule is issued.

Five-Year Review of Work Relative Values

The Health Care Financing Administration is required to conduct a review of the entire relative value scale every five years. Because the Medicare Fee Schedule was first used in 1992, the initial revision must be completed by 1997. This revision is being confined to the work relative values because practice expense and malpractice expense relative values remain charge based.

The five-year review process began in December 1994, when HCFA invited public comments on all work relative values. In total, the agency received about 500 comments on 1,100 codes. HCFA's carrier medical directors submitted comments on about 900 codes, two-thirds of which noted potentially overvalued services. Specialty societies also identified codes for consideration. After reviewing the comments, HCFA

referred a subset of these codes to the AMA/Specialty Society Relative Value Scale Update Committee (RUC) for evaluation.

The RUC met in August 1995 and February 1996, and made recommendations to HCFA on more than 1,100 Current Procedural Terminology (CPT) codes. The committee recommended increases in the work relative values for some 300 codes, decreases for about 100, and no change for more than 650 codes. Recommendations to HCFA on a few codes, including the anesthesia work relative values, are still pending. Additionally, the RUC referred some codes to the CPT Editorial Panel for possible coding changes before their relative values were reviewed. The work relative value changes recommended by the committee seem to reflect both refinement of values believed to have been assigned incorrectly at the inception of the relative value scale and corrections to accommodate changes in the work of individual services since that time.

HCFA is reviewing these recommendations with its carrier medical directors and will publish proposed values in a Notice of Proposed Rulemaking. After HCFA reviews comments from the public and makes final revisions, the new work relative values will be issued in the fall of 1996. They will be used for payment beginning in January 1997.

The Commission plans to analyze the results of this process and determine the effects of the changes on physician payment. It will also evaluate the methods used in this five-year review to develop recommendations for how to improve the next one.

Fee Schedule Payment Areas

The current fee schedule payment areas are based on the payment localities carriers established under the CPR charge-based payment system that preceded introduction of the fee schedule. Carriers had established these for a variety of economic, political, and administrative reasons, with resulting area constructs that showed wide variation in size and population nationwide. While many states defined single statewide areas, one had over 30 when the fee schedule was implemented.

The continued use of these arbitrary payment areas is somewhat incongruous with the otherwise systematic approach to payment under the fee schedule. The Commission has made a recommendation for redefining the payment areas based on metropolitan statistical areas (MSA) and continued to study this issue for over five years (PPRC 1991). More recently, HCFA contracted with HER to analyze alternative definitions of payment areas. The contractor's final report recommends an approach that builds from the current areas. This section briefly describes and compares the two approaches.

As part of physician payment reform, the Congress asked the Commission to study the geographic impact of the fee schedule, including the issue of defining payment areas. In its 1991 annual report, the Commission recommended that Congress redefine the areas.[8] In particular, it recommended subdividing

[8] Any change in fee schedule payment areas will also affect payments under Medicare's risk program, which are based on average fee-for-service spending for Medicare beneficiaries.

into substate areas only those states with a high degree of within-state price variation, leaving the rest as statewide areas. In states with high price variation, payment areas would be defined according to MSA population categories, so that, for example, a state's MSAs with populations between 1 and 3 million would define one payment area. The recommendations were based partly on earlier analyses conducted by HER under contract with the Commission.

As it discussed this issue, the Commission developed a set of criteria for comparing alternative definitions. These related to the:

- accuracy of tracking variation in prices,
- magnitude of differences at area boundaries, and
- administrative and conceptual simplicity.

The Commission concluded that other policy goals, such as ensuring access to care in underserved areas, should be addressed explicitly through other adjustment factors. In its view, geographic adjustment of the fee schedule is simply meant to reflect input price differences across the country.

The first step in the Commission's approach was to identify states that should be treated as statewide areas. It analyzed within-state price variation as captured by the county-level geographic adjustment factor for a typical service.[9] With this measure, only 15 states were identified with enough price heterogeneity that substate areas were thought to be necessary. The Commission concluded that all other states should constitute statewide areas.

For states with a high degree of price heterogeneity, substate areas were created by grouping metropolitan areas into four population categories and the remaining rural parts of each state into a fifth category. In many cases, states would have fewer than five payment areas because they do not contain cities in each population category. The proposed approach was based on the fact that price levels are highly correlated with population, so that it provides a reasonable balance between simplicity and input price tracking.

As it discussed the issue of boundary differences, the Commission realized that metropolitan areas that cross state borders pose a particular problem with regard to defining logical payment areas.[10] Historically,

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[9] Because each component of the fee schedule has its own GPCI within each payment area, a single adjustment is not made to total payments in the area. Instead, each service has a unique GAF within each area, which reflects the share of the service's total relative values due to each of the three components of the fee schedule. For analytical purposes, it is convenient to think about the pattern of payments across areas that would obtain for a typical service, that is, a service for which the physician work, practice expense, and malpractice expense each accounts for the same share of the service's total relative value as the three components account for overall spending. The fee schedule was based on revenue share data that revealed that 54.2 percent of revenues were accounted for by physician net income (physician work), 41.0 by practice expenses, and 4.8 percent by malpractice expenses. Therefore, the GAF for a typical service is calculated in each area by taking the weighted average of the area's three GPCIs, where the weights match these three revenue shares.

[10] There are more than 30 border-crossing MSAs. They contain nearly one-tenth of the nation's population.

the Washington, DC, area has constituted the only border-crossing Medicare payment area. The Commission concluded that, for a variety of reasons, metropolitan areas that cross state lines should not be divided for payment purposes. First, the definition of MSAs is designed to encompass areas that function as integrated economic markets. To the extent that an MSA is indeed a single market (or a complicated network of indistinguishable, overlapping markets), then allowing a state line to create an arbitrary payment differential may disrupt physician and patient purchasing and care patterns. Second, some of the data used to develop the GPCIs are based on information collected at the MSA level, so dividing MSAs along state boundaries and averaging one state's portion with other areas of the state can result in GAFs that differ within the MSA even though the underlying data cannot be used to identify price differences within the MSA.[11] As a result, the Commission recommended treating each border-crossing MSA as if it fell entirely within the state having the largest share of the MSA's population, so that one GAF would apply throughout the area.

When it was considering this issue, the Commission was told by HCFA staff that the agency lacked the authority to institute a comprehensive redefinition of areas, given OBRA89's direction to use the previous localities. Instead, HCFA developed a new policy of allowing physicians to ask that their states be converted to statewide payment areas if they could demonstrate widespread support among all physicians, including those who were likely to experience payment reductions. In the past few years, several states have successfully filed for conversion to statewide payment areas and at least one petition has been rejected.[12]

More recently, HCFA concluded that it could in fact institute a wholesale change in areas without new legislative authority. Therefore, the agency contracted with HER to compare alternative approaches with current area definitions, with a goal of identifying areas that are simpler to understand and administer but still do an acceptable job of tracking prices. HER recommended retaining only those current payment areas with GAFs that exceed state averages by some threshold (HER 1995). This change would create more statewide areas and eliminate some payment areas in those states that continue to include some substate areas. According to HER, this option was recommended because it is based on current payment areas, reduces the number of areas, and does an acceptable job of tracking local price variation.[13]

HER proposes an iterative approach wherein a state's highest GAF would be compared with the mean GAF in all its other payment areas. If this difference were larger than some threshold, the high-GAF area

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[11] Another consideration for using MSA-based areas is the availability of data between decennial censuses to update the GAF, as required every three years.

[12] Since 1991, Iowa, Minnesota, Nebraska, North Carolina, Ohio, and Oklahoma have been converted to statewide areas under this policy.

[13] The HER report also includes recommendations on redefining substate areas in those few states where payment areas currently do not respect county borders or can otherwise be improved (HER 1995). With regard to those that use city or ZIP code definitions, HER notes that most would be incorporated into larger areas under its proposed revision and those remaining can be logically redefined to respect county borders, improving both administrative and conceptual simplicity. In addition, the report recommends more fundamental redefinition of areas in three states—Massachusetts, Missouri, and Pennsylvania—because the current definitions lead to perverse results under the recommended approach. These proposed revisions appear to make payment areas more logical and consistent, and so should be considered if a new approach is based on current areas. They are unnecessary for definitions based on other building blocks, such as MSAs.

would be left as a payment area, and the process repeated for the state's next highest-priced area.[14] The process would end when the difference between the area GAF and rest-of-state mean fell below the threshold. Then, the remaining payment areas would be combined into one area. Therefore, if the difference between the highest GAF in a state and the mean GAF in the rest of the state were within the threshold, the state would become a statewide area.

Under this approach, 14 states would be divided into substate areas. Although the number of divided states is similar under the HER and Commission approaches, the actual states affected differ somewhat. Massachusetts, Missouri, Kansas, and Virginia would be divided under the Commission's county-GAF variation approach but not under the HER approach. The opposite would hold for Maine, New Jersey, Oregon, and Washington. In addition, the Commission would divide Minnesota, but it was not included in HER's analysis because it is now a statewide area. In divided states, the number of resulting areas differs between the two approaches.

Because of both data and methodological differences between the Commission's previous analysis and HER's more recent project, the two sets of results are difficult to compare directly. First, at the time of the Commission's analysis, only 1980 census data were available. Since the fee schedule had not yet been implemented, there was no standardized utilization measure available for use as weights, so population weighting was used. The newer study mirrors the recently revised GPCIs by using 1990 census data and utilization as measured by fee schedule relative values as weights. Second, there are two methodological differences between the two analyses. The Commission concluded that an MSA-based approach was appropriate while that recommended by HER builds from existing areas. In addition, each used a different approach to determine which states should be divided into substate areas. These differences affect both the states that should be divided into substate areas and the resulting areas within these states.

It is important to understand the contribution of both data and methodological factors to the different results in these studies. If the use of newer data and weights leads to a dramatically different view of price homogeneity within states, then the definition of payment areas should be revisited periodically. Identifying differences caused by the use of MSAs instead of current areas and by methodological differences in choosing statewide areas may help determine the most appropriate approach. Analyses described in a technical appendix to this chapter suggest that although newer data lead to different estimates of price variation and GAFs within a given approach, the methodological differences between the two studies account for their different conclusions about within-state price variation and proposed substate areas. The differences in estimates due solely to new data have led the Commission to recommend that, whatever payment area definition is ultimately selected, a periodic review be conducted to ensure that areas are logically and consistently defined over time.[15]

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[14] The report suggests use of either a 5 percent or 3.5 percent threshold in determining when to stop the iterative comparison of area GAFs to rest-of-state means. All results reported here are based on the 5 percent threshold.

[15] Use of newer data alone would have led the Commission to treat Louisiana as a statewide area, whereas earlier data suggested that there was a fairly high degree of intrastate price variation at the county level.

The HER report to HCFA does not directly address the policy question of whether MSAs that cross state borders should be subdivided for payment purposes. The Commission is concerned, however, that the recommended approach could lead to relatively large differences within such areas. Under the recommended approach, for example, Ohio and West Virginia, which share four metropolitan areas, would have statewide GAFs that differ by more than 5 percent. The Commission hopes that, regardless of the approach HCFA adopts for determining substate areas, the agency will consider its recommendation that border-crossing metropolitan areas not be divided for payment purposes.

Maintaining the Integrity of the Medicare Fee Schedule

The Commission has previously proposed a framework for implementing payment policy changes so that they do not inadvertently disrupt the relationship of relative values across services or across components of the fee schedule (PPRC 1994, PPRC 1995).[16] It has also recommended previously that HCFA be given authority to achieve budget neutrality each year by changing the conversion factors when appropriate. HCFA had concluded that legislation prohibited it from doing so and has made necessary adjustments through across-the-board adjustments to the relative value units. Although this does not affect the relationship of relative values, it has made it complicated for other payers to use the fee schedule and to analyze fee schedule elements across time. In the final rule for the 1996 fee schedule, HCFA has, for the first time, reduced all three conversion factors instead of all relative values to compensate for other policy changes. This change is consistent with the Commission's recommended approach and should enhance other payers' ability to use the fee schedule.[17]

The budget-neutrality adjustment that will be required by the five-year review process, by contrast, should be made only within the work component of the relative value scale. Based on the Commission's framework, changes to work values alone should not affect the other two components of the fee schedule. If the five-year review's budget-neutrality adjustment were made on the conversion factors, the relative shares of the practice expense and malpractice expense components would be changed inappropriately. The revised work values should be introduced in a manner that does not change the share of payments attributable to physician work.

The issue of how the three components of the fee schedule relate to one another merits annual review. As shown above, the distribution of current payments under the fee schedule is slightly different from the expected shares and fairly different from more recent survey data on revenue shares. Recent revenue data from the AMA surveys suggest that practice expenses have grown relative to the other two components. The Commission recommends that the components of the fee schedule be rebased relative to one another

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[16] The Commission has proposed that implementation of policy changes reflects three principles: the relative value scale should be usable by all payers; changes in the relative values for a service should be made only to make resource-based payment more accurate; and changes in the shares of total payments of the aggregate work, practice expense, and malpractice expense components should be made only to improve the accuracy of the relationships among them (PPRC 1994).

[17] Part of the adjustment was due to changes in refinement of relative values. Ideally, whatever share of the adjustment was due to such changes should be made within the component being refined. For example, if all relative value changes were made to work values, then all work values should be adjusted to compensate for these refinements. The share of adjustment due to introduction of new services to the fee schedule or coverage changes is appropriately made to the conversion factors.

annually, using current revenue share data. Such annual adjustments should be modest in size. HCFA has indicated its plans to use up-to-date share information for future GPCI updates, which is appropriate. It is not clear, however, whether the agency plans to rebase the fee schedule components using such information. Currently, both the GPCIs and the fee schedule reflect revenue shares as reported in the AMA's 1989 survey.

Payment for Investigational Devices and Other Services

In 1995, the Commission recommended that Medicare pay up to the cost of standard care when investigational devices and other services are clearly substituting for covered services and are being evaluated in studies approved by the Food and Drug Administration (FDA) or other federal agency (PPRC 1995). Since the Commission issued its recommendation, HCFA has changed its payment policy for the use of investigational devices. The FDA is classifying investigational devices into two categories. Category A devices are new, first-generation devices or previously approved ones that have been significantly modified. HCFA still does not consider these devices eligible for payment because their safety and efficacy have not been established sufficiently to qualify for coverage. Category B devices are improved versions or new generations of currently approved devices. Services associated with use of a Category B device in an appropriate clinical trial will now be eligible for Medicare coverage up to the costs associated with use of the comparable approved device.[18]

The FDA and HCFA have completed classifying some 1,100 devices now being tested under an investigational device exemption. More than 90 percent were placed into Category B, making them eligible for coverage. Some implementation issues remain to be resolved, including whether some mechanism is needed to ensure the accuracy of the classification of devices into the two categories. The Commission plans to monitor the success of this new payment policy as it continues to be implemented.

It is encouraging that Medicare beneficiaries will be able to participate in many investigational device trials due to HCFA's new policy. Since the Commission's recommendation did not make any distinction between Category A and B devices, it would extend this special coverage to both types of devices. The Commission's recommendation would also apply to other new investigational services, in addition to devices.

Technical Appendix: Comparison of HER and Commission Payment Area Analyses

As described in the chapter, the analyses of payment areas that HER recently conducted for HCFA differ from those done by the Commission several years ago with respect to both data and methods. This appendix briefly summarizes the differences in data and method and the contribution of each to the different conclusions reached in the two studies.

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[18] The use of Category B devices must otherwise qualify for Medicare coverage, i.e., be reasonable and necessary.

DATA AND WEIGHTS

HER's analysis uses 1990 census data and total fee schedule relative value units by county to analyze alternative payment area definitions. These data and weights were also used in the recently updated GPCIs, so the HER analyses present GAF estimates that are budget neutral with regard to current payments. When the Commission conducted its analyses before the fee schedule was implemented, it used the same resources as the then-current GAFs, namely the 1980 census and population weighting. As a result, its estimates were budget neutral with regard to payments at the time, but are no longer. Therefore, these two sets of estimates are difficult to compare directly.

The role of newer data and the more appropriate utilization weights can be discerned by using the same method to calculate GAF estimates from both earlier and more recent data. In the Commission's earlier analysis, intrastate price variation was determined through the standard deviation in the county-level GAF for a typical service within each state. Under this approach and the older data, 15 states appeared to have a level of variation that merited using substate areas.[19] Estimates based on the newer data suggest that although actual variances have changed in many cases, states exhibit roughly the same degree of variation as before. Only one of the states that had variation above the cutoff used in the Commission's earlier analysis—Louisiana— now has variation below that cutoff and no state has risen above the cutoff. The fact that HER's approach to measuring within-state price homogeneity leads to subdividing different states is therefore due primarily to differences in method rather than to the use of newer data and weights.

The HER report also includes GAF estimates under an approach similar to that recommended by the Commission but based on the newer data, which allows for another comparison of differences due to data rather than method (Table 9-5). Relative to the Commission estimates, the HER estimates would change the distribution of GAFs both within and across states. For example, all five GAFs in California are lower under the more recent estimates because the state mean GAF dropped from 1.112 to 1.061 under the recent GPCI revisions.

For more direct comparison of within-state GAF differences with the Commission's previous work, therefore, another set of GAFs was estimated with the newer information but which holds statewide averages the same. These adjusted HER estimates reveal, for example, that within California there has been a relative increase in the range of the GAF compared with the Commission estimates; if the state mean had not fallen given the newer data, the largest population MSAs would have GAFs of 1.157, compared with a previous value of 1.134, while the GAF in rural areas would have dropped from 1.014 to 1.003. Although these estimates reveal some relatively large GAF differences based on the two data sources, there was no qualitative change in within-state price heterogeneity as captured through the county-level variation described above. These estimates suggest that relative prices nationwide and the distribution of Medicare payments may change enough to merit periodic review, but the data differences in the two studies do not explain the disparate results.

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[19] There were 16 states above the standard deviation cutoff but in one case, Delaware, the high measure of price variation was thought to be an artifact of the small number of counties in the state (2), so the state was left as statewide under the Commission's approach.

Table 9-5. Estimates of Geographic Adjustment Factors for a Typical Service in the Payment Areas Recommended by the Commission

State	Population Category	1991 PPRC Estimate	1995 HER Estimate	1995 Adjusted HER Estimate
Alabama		0.925	0.932	0.925
Arizona		1.002	0.995	1.002
Arkansas		0.879	0.887	0.879
California	State mean	1.112	1.061	1.112
	Over 3 million	1.134	1.103	1.156
	1-3 million	1.125	1.069	1.120
	.25-1 million	1.072	1.015	1.064
	Under .25 million	1.039	0.987	1.034
	Nonmetro areas	1.014	0.956	1.002
Colorado		0.972	0.966	0.972
Connecticut		1.052	1.106	1.052
Delaware		0.999	1.015	0.999
District of Columbia		1.099	1.090	1.099
Florida	State mean	0.985	1.023	0.985
	1-3 million	1.019	1.053	1.014
	.25-1 million	0.967	1.004	0.967
	Under 25 million	0.956	0.968	0.932
	Nonmetro areas	0.931	0.955	0.920
Georgia	State mean	0.931	0.966	0.931
	1-3 million	0.979	1.010	0.973
	.25-1 million	0.925	0.951	0.917
	Under .25 million	0.915	0.940	0.906
	Nonmetro areas	0.890	0.912	0.879
Idaho		0.952	0.911	0.952
Illinois	State mean	1.054	1.011	1.054
	Over 3 million	1.108	1.061	1.106
	1-3 million	--	0.986	1.028
	.25-1 million	1.035	0.937	0.977
	Under .25 million	0.981	0.948	0.988
	Nonmetro areas	0.952	0.889	0.927
Indiana		0.938	0.925	0.938
Iowa		0.928	0.912	0.931
Kansas	State mean	0.936	0.945	0.936
	1-3 million	--	0.982	0.973
	.25-1 million	0.965	0.970	0.961
	Under .25 million	0.942	0.962	0.953
	Nonmetro areas	0.901	0.896	0.887

Table 9-5. (continued)

State	Population Category	1991 PPRC Estimate	1995 HER Estimate	1995 Adjusted HER Estimate
Kentucky		0.921	0.921	0.921
Louisiana	State mean	0.956	0.943	0.956
	1-3 million	1.005	0.977	0.990
	.25-1 million	0.968	0.934	0.947
	Under .25 million	0.944	0.923	0.936
	Nonmetro areas	0.911	0.893	0.905
Maine		0.933	0.959	0.933
Maryland	State mean	1.042*	1.016	1.042
	1-3 million	1.024	1.032	1.058
	.25-1 million	--	0.998	1.024
	Under .25 million	0.952	0.937	0.961
	Nonmetro areas	0.954	0.960	0.985
Massachusetts	State mean	1.037	1.075	1.037
	Over 3 million	1.062	1.084	1.045
	.25-1 million	0.991	1.019	0.983
	Under .25 million	0.980	1.040	1.003
	Nonmetro areas	1.018	1.012	0.976
Michigan	State mean	1.057	1.083	1.057
	Over 3 million	1.113	1.137	1.110
	.25-1 million	1.029	1.036	1.011
	Under .25 million	1.000	1.008	0.984
	Nonmetro areas	0.972	0.975	0.952
Minnesota	State mean	0.970	na	0.970
	1-3 million	1.005	na	na
	.25-1 million	0.961	na	na
	Under .25 million	0.952	na	na
	Nonmetro areas	0.924	na	na
Mississippi		0.897	0.899	0.897
Missouri	State mean	0.960	0.954	0.960
	1-3 million	0.993	0.984	0.990
	.25-1 million	--	0.921	0.927
	Under .25 million	0.936	0.924	0.930
	Nonmetro areas	0.916	0.891	0.897
Montana		0.940	0.907	0.940
Nebraska		0.901	0.894	0.901
Nevada		1.044	1.010	1.044
New Hampshire		0.972	1.003	0.972
New Jersey		1.085	1.085	1.085

Table 9-5. (continued)

State	Population Category	1991 PPRC Estimate	1995 HER Estimate	1995 Adjusted HER Estimate
New Mexico		0.951	0.937	0.951
New York	State mean	1.101	1.115	1.101
	Over 3 million	1.165	1.176	1.161
	1-3 million	1.135	1.116	1.102
	.25-1 million	0.998	0.996	0.983
	Under .25 million	1.007	0.945	0.933
	Nonmetro areas	0.956	0.952	0.940
North Carolina		0.900	0.924	0.900
North Dakota		0.919	0.898	0.919
Ohio		0.971	0.973	0.971
Oklahoma		0.919	0.910	0.919
Oregon		0.993	0.949	0.993
Pennsylvania	State mean	1.001	0.991	1.001
	Over 3 million	1.070	1.066	1.077
	1-3 million	0.988	0.963	0.973
	.25-1 million	0.972	0.960	0.970
	Under .25 million	0.964	0.919	0.928
	Nonmetro areas	0.952	0.918	0.927
Rhode Island		0.989	1.068	0.989
South Carolina		0.899	0.915	0.899
South Dakota		0.893	0.880	0.893
Tennessee		0.906	0.923	0.906
Texas	State mean	0.938	0.962	0.938
	Over 3 million	--	1.030	1.004
	1-3 million	0.973	0.978	0.954
	.25-1 million	0.935	0.947	0.923
	Under .25 million	0.922	0.926	0.903
	Nonmetro areas	0.886	0.895	0.873
Utah		0.959	0.926	0.959
Vermont		0.930	0.955	0.930
Virginia	State mean	0.958*	0.944	0.958
	1-3 million	0.944	0.951	0.965
	.25-1 million	0.927	0.973	0.987
	Under .25 million	0.916	0.933	0.947
	Nonmetro areas	0.903	0.900	0.913

Table 9-5. (continued)

State	Population Category	1991 PPRC Estimate	1995 HER Estimate	1995 Adjusted HER Estimate
Washington		1.018	0.982	1.018
West Virginia		0.933	0.919	0.933
Wisconsin		0.952	0.968	0.952
Wyoming		0.954	0.926	0.954

SOURCE: Physician Payment Review Commission 1991, Health Economic Research 1995.

* Maryland and Virginia state means include the areas within each state that are in the Washington, DC, payment area, which is listed separately.

NOTES: The Geographic Adjustment Factor for a typical service reflects price shares for physician work, practice expense, and malpractice expense of 0.542, 0.410, and 0.048, respectively.

The adjusted 1995 HER estimates are budget neutral within each state relative to the 1991 PPRC estimates. The 1995 HER values reallocate payments across states, relative to the 1991 PPRC estimate, consistent with the effect of the current Geographic Practice Cost Indexs relative to those originally implemented with the fee schedule.

Estimates are not available for Minnesota. Because it is currently a statewide payment area, it was excluded from the HER analysis.

METHODS

There are two methodological differences between the two analyses. As described above, the use of within-state price variation at the county level leads to a different view of state price homogeneity than the HER approach of comparing high-GAF areas to the rest-of-state mean. In particular, the former approach suggests that Massachusetts, Missouri, Kansas, and Virginia have a high degree of price variation but that Maine, New Jersey, Oregon, and Washington do not, while the latter reaches the opposite conclusion about these eight states. Under the Commission's approach, newer data would have changed the treatment of only one state—Louisiana—and therefore do not account for differences in the two studies' conclusions about within-state price variation. The disparate conclusions are the result, therefore, of the differences in method used to identify high-price variation states.

To disentangle the effect of using current payment areas instead of MSAs as building blocks, the Commission contracted with HER to replicate its recommended iterative approach based on MSAs. Applying this approach to MSAs instead of fee schedule areas (FSA) results in a total of 99 payment areas, compared with 87 under HER's FSA approach. In seven cases, the MSA approach would divide states that the FSA approach would make into single statewide areas, while the opposite is true for two other states (Table 9-6).[20] In some cases, this may be due to the treatment of border-crossing MSAs.

[20] Indiana, Kansas, Kentucky, Mississippi, Missouri, Virginia, and West Virginia would be divided under the MSA approach but not the FSA approach, while the opposite is true for New Jersey and Oregon.

Table 9-6. Payment Areas under Health Economic Research Iterative Approach Applied to Fee Schedule Areas (FSA) and to Metropolitan Statistical Areas (MSA)

State	Number of Current FSAs	FSA-Based Iterative Approach		MSA-Based Iterative Approach	
		Number of Areas	GAF for "Rest-of-State" area	Number of Areas	GAF for "Rest-of-State" Area
Alabama	6	1	0.932	1	0.932
Arizona	6	1	0.995	1	0.995
California	28	9	1.007	10	1.003
Connecticut	4	1	1.106	1	1.106
Florida	4	3	0.984	4	0.986
Georgia	4	2	0.935	2	0.932
Idaho	2	1	0.911	1	0.911
Illinois	16	4	0.924	4	0.913
Indiana	3	1	0.925	2	0.925
Kansas	3	1	0.945	4	0.898
Kentucky	3	1	0.921	2	0.920
Louisiana	8	2	0.926	2	0.923
Maine	3	2	0.937	2	0.940
Maryland	3	2	0.964	2	1.016
Massachusetts	2	1	1.075	1	1.075
Michigan	2	2	1.012	3	1.012
Mississippi	2	1	0.899	3	0.886
Missouri	7	1	0.954	3	0.908
Nevada	4	1	1.010	1	1.010
New Jersey	3	2	1.051	1	1.085
New York	8	5	0.973	5	0.974
Oregon	5	2	0.934	1	0.949
Pennsylvania	4	3	0.939	3	0.951
Texas	32	8	0.924	8	0.921
Virginia	4	1	0.966	2	0.940
Washington	3	2	0.962	2	0.959
West Virginia	5	1	0.919	2	0.918
Wisconsin	11	1	0.968	1	0.968

SOURCE: Health Economic Research analysis of 1990 county input price file.

NOTES: States that are currently statewide payment areas were excluded from analysis.

A 5 percent threshold was used to compare the area Geographic Adjustment Factor (GAF) with rest-of-state mean GAF under both FSA and MSA approaches.

The GAF for the rest-of-state area gives some insight into how similarly the two approaches actually divide states (Table 9-6). For example, even though each approach creates four payment areas in Illinois, the GAF in the rest-of-state area is somewhat different: 0.924 under the FSA approach and 0.913 under the MSA approach. This suggests that either different communities are singled out to form the three city-specific areas or that, if the same communities are the source of these three areas, the FSA definition of the areas is quite different from the MSA definition. In the case of Illinois, the MSA approach roughly groups together two FSAs (Chicago and Suburban Chicago). It also singles out the Springfield MSA as a separate

area, though this FSA is not retained as a separate area under the FSA approach. GAF differences in Georgia are due entirely to how Atlanta is defined under each approach.

Table 9-7. Distribution of Relative Value Units (RVUs) under Alternative County Geographic Adjustment Factors (GAFs), based on Iterative Approach Applied to Fee Schedule Areas (FSA) and to Metropolitan Statistical Areas (MSA)

State	GAFs Within 1 Percent	MSA GAF Greater Than FSA GAF by More Than 1 Percent		MSA GAF Less Than FSA GAF by More Than 1 Percent	
	Percent RVUs	Percent RVUs	Mean Change	Percent RVUs	Mean Change
Alabama	100.0	-	-	-	-
Arizona	100.0	-	-	-	-
California	90.0	5.2	5.2	4.8	-2.2
Connecticut	100.0	-	-	-	-
Florida	80.4	10.7	4.3	9.0	-6.7
Georgia	96.5	3.4	8.0	0.1	-7.8
Indiana	100.0	-	-	-	-
Illinois	47.7	24.1	2.5	28.2	-1.3
Indiana	99.5	0.5	5.8	-	-
Kansas	0	62.0	3.1	38.0	-5.0
Kentucky	93.2	6.8	6.3	-	-
Louisiana	96.3	3.7	5.5	-	-
Maine	92.2	-	-	7.8	-5.2
Maryland	0	23.8	6.9	76.2	-1.6
Massachusetts	100.0	-	-	-	-
Michigan	91.3	3.7	10.9	5.0	-5.5
Mississippi	0	23.4	4.8	76.6	-1.5
Missouri	0	60.7	3.1	39.3	-4.8
Nevada	100.0	-	-	-	-
New Jersey	0	40.7	3.2	59.3	-2.2
New York	54.4	27.2	2.3	18.4	-4.2
Oregon	0	68.3	1.6	31.7	-3.3
Pennsylvania	0	66.5	2.7	33.5	-5.6
Texas	95.0	5.0	8.2	-	-
Virginia	0	5.9	12.8	94.1	-2.7
Washington	93.9	6.1	5.9	-	-
West Virginia	97.2	2.8	18.6	-	-
Wisconsin	100.0	-	-	-	-

SOURCE: Health Economic Research analysis of 1990 county input price file.

NOTE: States that are currently statewide payment areas were excluded from analysis.

GAF estimates are based on 5 percent threshold in iterative approach for both FSA and MSA configurations.

To compare the two approaches more systematically, county-level GAF differences were calculated and weighted by county Medicare relative value units (Table 9-7). These estimates show that in 11 states, more

than 10 percent of RVUs would have been paid GAFs that differ by over 1 percent under the two approaches. In 8 of these 11 states, all RVUs would have different GAFs; 4 of these 8 are statewide under the FSA approach but are subdivided under the MSA approach. In most cases, however, the percentage differences between the GAFs is fairly modest. Although all GAFs in Oregon would change more than 1 percent, for example, the mean change among those that are higher under the MSA approach is only 1.6 percent; the mean drop is 3.3 percent.

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Improving the Volume Performance Standard System

Increases in Medicare's fee-for-service spending for physicians' services may occur due to rising prices or growth in the number and mix of services per beneficiary (also called volume and intensity growth). Because price restraints were used to control spending during the 1970s and 1980s, by the late 1980s, volume and intensity growth had become the primary cause of higher program spending. In fact, from 1986 until 1992, while physician payment rates grew less than 2 percent annually, the volume and intensity of services per beneficiary rose almost 8 percent per year (Board of Trustees 1994).

The Volume Performance Standard (VPS) system, established by the Omnibus Budget Reconciliation Act of 1989 (OBRA89), curbs the rise in spending for physicians' services in Medicare by linking payment levels to the growth in the volume and intensity of services. Payment levels under the Medicare Fee Schedule are determined by relative values units and conversion factors that translate relative values into dollar amounts for each service. The VPS system operates by setting target rates of expenditure growth for physicians' services, and then adjusting conversion factors two years later, depending on whether expenditure growth met the targets. Target rates of expenditure growth are called performance standards; adjustments to payment levels based on these standards are called conversion factor updates.

The Commission has long held that a budgeting tool like the VPS system is necessary to constrain spending for physicians' services, but has also warned that methodological flaws keep the system from working as intended. A revision to the VPS system, proposed by the Congress and the Administration, would incorporate many of the Commission's previous

This chapter includes:

- *Description of the current Volume Performance Standard system*
- *Limitations of the Volume Performance Standard system*
- *Description of the proposed revision, called the Sustainable Growth Rate system*
- *Limitations of the Sustainable Growth Rate system*
- *Comparison of potential impact on physician payment of current and proposed systems*

recommendations to correct these limitations. The proposed revision, called the Sustainable Growth Rate system, would establish a single conversion factor that would remove the current distortion created by multiple conversion factors. It would also set a target linked to growth in gross domestic product (GDP) instead of the five-year historical trend for volume and intensity growth of physicians' services currently used under the VPS system. Conversion factor updates would be based on comparisons of total actual versus allowed spending accrued since a base year, replacing the year-to-year comparisons and two-year delay in the current system.

Two limitations of both the proposed and current VPS system are inherent to any administered price system. These limitations include difficulties establishing targets that reflect an appropriate level of care and reducing volatility in annual adjustments to the conversion factor. A third limitation may ensue from inaccuracies in projections of inflation and enrollment rates. Because these projections are used to calculate conversion factor updates, the updates may reflect these inaccuracies. This limitation, however, can be avoided by making corrections for any projection errors.

Recommendation

Any revision to the Volume Performance Standard system should annually correct for any projection errors in the target growth rate from prior years.

This chapter first describes the current VPS system and discusses the implications of its methodological flaws. It then explains how the Sustainable Growth Rate system would operate and how it would correct problems stemming from the current system. Some potential limitations of the proposed approach are noted. The chapter concludes by comparing the two systems for constraining spending for physicians' services, and illustrating the potential impact these systems may have on physician payment levels.

THE VOLUME PERFORMANCE STANDARD SYSTEM

To control spending for physicians' services, the VPS system uses performance standards to set target rates of expenditure growth and adjusts conversion factors annually, depending on whether expenditure growth met the targets. First, performance standards are determined for a given year. Two years later, actual expenditure growth for that year is compared with the performance standards. The conversion factors are then increased or reduced, depending on whether actual expenditure growth fell below or above the performance standards.

The first performance standard was set in 1990. Physicians were expected to hold expenditure growth for all services to no more than 9.1 percent (Table 10-1). The 1990 performance standard was compared to actual expenditures to determine the update to the conversion factor for 1992 (Table 10-2). A single performance standard was used to cover all physicians' services for the first year only. Separate performance standards for surgical services and nonsurgical services were used for the next two years. A third category for primary care services was added under OBRA93.[1]

[1] These categories are defined according to the type of service rather than the specialty of the physician. For example, an office visit provided by a surgeon would fall into the primary care category.

Table 10-1. Performance Standards, by Category of Service, 1990-1996 (percentage)

Category of Service	1990	1991	1992	1993	1994	1995	1996
All Services	9.1%	7.3%	10.0%	10.0%	9.3%	7.5%	1.8%
Surgical Services	-	3.3	6.5	8.4	-	-	-
Nonsurgical Services		8.6	11.2	10.8	-	-	-
Surgical Services	-	-	-	-	9.1	9.2	-0.5
Primary Care Services	-	-	-	-	10.5	13.8	9.3
Other Nonsurgical Services	-	-	-	-	9.2	4.4	0.6

SOURCE: Physician Payment Review Commission compilation of performance standards as reported in the *Federal Register*.

Table 10-2. Conversion Factor Updates, by Category of Service, 1992-1996 (percentage)

Category of Service	1992	1993	1994	1995	1996
All Services	1.9%	-	-	-	-
Surgical Services	-	3.1%	-	-	-
Nonsurgical Services	-	0.8	-	-	-
Surgical Services	-	-	10.0%	12.2%	3.8%
Primary Care Services	-	-	7.9	7.9	-2.3
Other Nonsurgical Services	-	-	5.3	5.2	0.4

SOURCE: Physician Payment Review Commission compilation of conversion factor updates as reported in the *Federal Register*.

This year's performance standards are the lowest since the inception of the VPS system. In addition, 1996 is the first year with a negative performance standard and update. The 1996 performance standards are –0.5 percent for surgical services, 9.3 percent for primary care services, and 0.6 percent for other nonsurgical services (Table 10-1). The 1996 conversion factor updates are 3.8 percent for surgical services, –2.3 percent for primary care services, and 0.4 percent for other nonsurgical services (Table 10-2). As a result, the conversion factors are $40.80 per relative value unit (RVU) for surgical services, $35.42 for primary care services, and $34.63 for other nonsurgical services (Table 10-3).[2]

The VPS system relies on input from several sources to set performance standards and conversion factor updates. The Secretary of Health and Human Services must make recommendations on performance

[2] Changes to the relative value units and other payment policy changes for the 1996 fee schedule would have increased spending. Hence, the Health Care Financing Administration reduced the conversion factors by 0.36 percent to make the changes to the relative value units budget neutral.

Table 10-3. Conversion Factors, by Category of Service, 1992-1996 (dollars)

Category of Service	1992	1993	1994	1995	1996
All Services	$31.00	-	-	-	-
Surgical Services	-	$31.96	-	-	-
Nonsurgical Services	-	31.25	-	-	-
Surgical Services	-	-	$35.16	$39.45	$40.80*
Primary Care Services	-	-	33.72	36.38	35.42*
Other Nonsurgical Services	-	-	32.90	34.62	34.63*

SOURCE: Physician Payment Review Commission compilation of conversion factors as reported in the *Federal Register*.

* These conversion factors include an additional 0.36 percent reduction due to a budget-neutrality adjustment. This adjustment offsets increases in spending from changes to the relative value units and other payment policy changes for 1996.

standards and updates to the Congress by April 15 of each year for the next calendar year. The Commission must review and comment on those recommendations, and make its own by May 15. The Congress may adopt these recommendations or set its own updates and performance standards. Otherwise, they are determined by default formulas.

These default formulas are central to the VPS system because they are often used to determine the performance standards and updates. Even when the Congress has chosen to deviate from them, the default formulas have been a starting point for congressional deliberation. In addition, they establish the baseline levels of spending that alternative systems cannot exceed. When options for Medicare payment to physicians are considered, the spending associated with each is compared with that under the default formulas. Under current budget rules, an option that would raise spending cannot be adopted unless the higher spending is offset either by increasing tax revenues or by making spending cuts elsewhere.

Performance Standards

Performance standards are target rates of expenditure growth that reflect four factors: changes in the number of Medicare beneficiaries; inflation; volume and intensity growth; and changes in spending due to changes in law and regulations. The performance standards allow for all four components of expenditure growth except volume and intensity growth. Because physicians have some discretion over volume and intensity growth, the VPS system holds them collectively accountable for changes in this component. Consequently, determining the appropriate rate of growth for volume and intensity of physicians' services is the most critical aspect of setting performance standards. The factors used to calculate the 1996 default performance standards are shown in Table 10-4.

Default performance standards are calculated in two steps. First, the five-year historical trend of volume and intensity growth is multiplied by the percentage change in the input price for physicians' services, Part

Table 10-4. Components of Expenditure Growth, for 1996 Default Performance Standards, by Category of Service (percentage)

Components	Category of Service		
	Surgical	Primary Care	Other Nonsurgical
Inflation	2.1%	2.1%	2.3%
Enrollment Growth	-0.3	-0.3	-0.3
Volume and Intensity Growth	2.3	5.3	5.1
Changes in Law and Regulation	-0.6	5.7	-2.4

SOURCE: HCFA 1995.

B enrollment excluding Medicare beneficiaries covered by risk contracts, and spending due to changes in law and regulations.[3] Second, a 4 percentage point deduction is taken to reflect the intent to slow the growth rate of expenditures.[4]

The 1996 performance standard for primary care services illustrates this process (Table 10-5). First, the product is taken for the changes in the four components of expenditure growth: inflation (2.1 percent); enrollment growth (–0.3 percent); volume and intensity growth (5.3 percent); and law and regulations (5.7 percent). Next, 4 percentage points are subtracted to obtain the 9.3 percent performance standard for primary care services.

Conversion Factor Updates

The VPS system also annually adjusts the conversion factors to reflect differences between the performance standards and actual expenditure growth rates. As a result, the conversion factors are increased when physicians' spending falls below the target rates but reduced when the targets are exceeded. The adjustments depend on the change in the Medicare Economic Index (MEI) and comparisons of actual expenditure growth and the performance standards two years earlier. The MEI, a measure of medical price inflation, reflects changes in rents, supplies, professional wages, and other costs incurred by physicians' practices.

The conversion factor updates are thus the estimate of the MEI plus a performance reward or penalty, determined by how much actual expenditures are below or above the performance standards.[5] To

[3] The annual updates to the conversion factor are reflected in two components of expenditure growth: inflation and changes in spending due to changes in law and regulations. Inflation is measured as a weighted average of input price increases [estimated by the Medicare Economic Index for physicians' services and the Consumer Price Index for Urban Consumers (CPI-U), for laboratory services]. Changes in the annual update resulting from the VPS penalty or bonus are accounted for as changes in spending due to changes in law and regulations.

[4] When the VPS system was first implemented, the deduction was 0.5 percentage points. This was gradually increased to 2.0 percentage points; beginning in 1995, it was raised to 4.0 percentage points.

[5] In some years, statutory reductions have been taken from the MEI. For example, for 1995 the MEI was reduced by 2.7 percentage points for surgical and other nonsurgical services. There was no reduction for primary care services.

Table 10-5. Calculation of the 1996 Default Performance Standards, by Category of Service

	(Inflation	X	Enrollment	X	Volume	X	Law)	-	Performance Standard Factor	=	Performance Standard
Surgical Services	1.021		0.997		1.023		0.994		0.040		0.995
Primary Care Services	1.021		0.997		1.053		1.057		0.040		1.093
Other Nonsurgical Services	1.023		0.997		1.051		0.976		0.040		1.006

SOURCE: HCFA 1995.

avoid the possibility of a substantial penalty in any given year, the penalty is limited to 5 percentage points.

The calculation of the 1996 conversion factor update of –2.3 percent for primary care services is illustrative. The 1996 MEI was an estimated 2.0 percent. Expenditure growth for 1994 primary care services was estimated at 14.8 percent and the performance standard was 10.5 percent. A VPS penalty of –4.3 percent (10.5 percent minus 14.8 percent) was therefore deducted from the estimated MEI to obtain a –2.3 percent conversion factor update for primary care services.

Overcoming VPS System Limitations

Methodological flaws within the current VPS system have led to several problems. Because of the three performance standards and updates, payment levels have become distorted, so that they no longer reflect the resource-based relative values underlying the Medicare Fee Schedule. Also, the VPS system will set increasingly unrealistic target rates of expenditure growth because it relies on historical trends and an arbitrary legislated reduction of 4 percentage points. Finally, because of the two-year delay, the VPS system does not fully account for all Medicare spending for physicians' services.

The Commission has previously made recommendations to eliminate these methodological flaws. Among these are adopting a single performance standard and update for all categories of services and linking the performance standard formula to projected growth in real GDP per capita while allowing an additional 1 or 2 percentage points for advancements in medical capabilities. The Commission has also recommended revising the method for determining the conversion factor update to eliminate the two-year delay and to compare actual and targeted spending accumulated since a base year. This section describes the current system's limitations and ways to resolve them.

Adopting a Single Performance Standard and Update. Determining separate performance standards and updates for different categories of service has distorted relative payments, which no longer reflect the fee schedule's resource-based RVUs. By applying different updates to each category, RVUs in different categories are not worth the same amount. This violates the basic principle underlying the resource-based

relative value scale, namely that relative payments should be determined solely by the RVUs attached to a given service.

Eliminating this distortion will require adopting a single conversion factor for all services, and using a single performance standard and update thereafter. Because of the wide dispersion in conversion factors that has already occurred, however, it may be advisable to move to a single conversion factor over several years to prevent any category from experiencing a large one-time increase or decrease.

Linking Performance Standards to Measures of GDP Growth. The use of historical trends and a fixed deduction of 4 percentage points may lead to unrealistic and arbitrary performance standards. High or low expenditure growth eventually becomes part of the historical trend in volume and intensity used to calculate the default performance standards. As a result, reducing volume and intensity growth increases the conversion factors in the short term, but lowers the performance standards over the longer term, making them more difficult to meet.

Embedding a fixed deduction of 4 percentage points in the performance standard formula is an inflexible approach that fails to reflect changes in medical practice or the general economy. In effect, the formula demands that no matter how much physicians restrain the number and intensity of services, they must further reduce volume and intensity by another 4 percentage points each year or receive lower updates. Lowering the current deduction of 4 percentage points is difficult to enact, however, because doing so would be scored in the budget process as increased spending. Current budget rules would then require offsetting higher spending by either raising tax revenues or by making spending cuts elsewhere.

Linking the performance standard formula to projected growth of real GDP per capita, instead of a five-year historical trend with a fixed deduction of 4 percentage points, would provide a realistic and affordable goal that links the budget targets to the economy as a whole. Projected GDP growth is an appropriate choice because it represents the economy's capacity to grow, while avoiding the effects of business cycles. Real, rather than nominal, GDP growth should be used since the formula already accounts for input price inflation; per capita growth should be used because the formula incorporates enrollment growth.

Accounting Fully for Spending for Physicians' Services. The calculation of the conversion factor update incorporates a two-year delay so that the update can be based on complete claims information. That is, by the time the 1996 conversion factor updates were derived, processing of claims for 1994 was substantially completed. Complete data are important because the formula makes only year-to-year comparisons without subsequent adjustments for more information. Unfortunately, this approach fails to capture shortfalls and surpluses that occurred during the intervening two years. For example, assume volume and intensity grew 2 percent per year above the 1994 and 1995 allowance. The 1996 conversion factor update would be adjusted downward to offset the 2 percent higher spending, thereby lowering spending for 1996 and subsequent years. The VPS system, however, would not recoup the higher spending that occurred in 1994 and 1995 because of the excess volume and intensity growth. Hence, the current VPS system does not fully account for all Medicare spending for physicians' services.

Calculating the conversion factor update by annually comparing actual and targeted spending accumulated since a base year would allow the system to account for all Medicare spending. With this method, the two-year delay could be eliminated because it would no longer be necessary to have complete claims data. Any spending not yet accounted for would be added to the accumulated spending totals in subsequent years.

THE PROPOSED SUSTAINABLE GROWTH RATE SYSTEM

Recent proposals by the Congress and the Administration would replace the current VPS system with the Sustainable Growth Rate system, which incorporates most of the Commission's past recommendations for improving the VPS system.[6] The proposed approach would use a new methodology that adopts a single conversion factor and uses projected growth of real GDP per capita. It would also eliminate the two-year delay and adjust the conversion factor annually to ensure that total actual spending accrued since a base year is held to target spending levels. The two components of the proposed approach are: the target rate of spending for physicians' services, called the sustainable growth rate, and the conversion factor update.

The Sustainable Growth Rate

Like the performance standards in the VPS system, the sustainable growth rate reflects changes in inflation, enrollment, and spending due to changes in law and regulations. Rather than relying on historical patterns of volume and intensity growth, however, it uses projected growth in real GDP per capita. The revision proposed by the Congress provides an additional 2 percentage points of growth to allow for advancements in medical capabilities. The Administration's proposal provides an allowance of 1 percentage point.

The following example illustrates how the sustainable growth rate would be calculated. Assume inflation is roughly 3.0 percent, growth in enrollment is 0 percent, and changes in spending due to changes in law and regulations is –3.1 percent.[7] Also assume that real GDP growth per capita is 2 percent, so that the 2 additional percentage points under the congressional proposal provides a 4 percent allowance for volume and intensity growth. Similar to the performance standard formula described earlier, the sustainable growth rate is the product of these four factors (3.8 percent in the example). Under the congressional proposal and growth of real GDP per capita of 2 percent through 2005, allowed growth would be roughly 6 percent to 7 percent per year. Under the same assumptions, the Administration's proposal would allow growth for physicians' spending of between 5 percent and 6 percent per year.

The Conversion Factor Update

Under the proposed approach, the conversion factor update for a given year would be calculated using a substantially different method than the one now used. The Sustainable Growth Rate system is designed so

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[6] These proposals assumed that implementation would begin January 1, 1996. Although this is no longer feasible, the discussion and examples provided are based on these proposals and hence reflect the 1996 implementation date.

[7] The –3.1 percent reflects the reduction in spending that would result from moving to a single conversion factor of $35.42. Other estimates reflect the 1995 March baseline from the Congressional Budget Office.

that projected spending will match target levels by the end of each year. Because of the inherent volatility in year-to-year expenditure growth, the system constrains the size of the annual updates. It limits increases to 103 percent of the MEI and reductions to 93 percent of the MEI. If the MEI is 2 percent, the conversion factor update has symmetric limits of about plus and minus 5 percent. When the limits are exceeded, the excess spending or surplus is accounted for in subsequent years.

The conversion factor update is calculated based on comparisons between total allowed accrued spending and total actual accrued spending, each accrued since 1995. The total accrued allowed spending is determined using the sustainable growth rate. For example, the annual allowed spending for 1996 is calculated by multiplying the 1996 sustainable growth rate by actual 1995 spending, the baseline level. Total accrued allowed spending is then calculated by summing up the allowed spending for each year. If the 1995 baseline spending is $33.2 billion, and the sustainable growth rate for 1996 is 3.8 percent, then the total accrued allowed spending for 1996 would be $67.7 billion (Table 10-6).

The conversion factor update is determined in several steps. First, an update adjustment factor is calculated as total allowed spending accrued through the given year, less total actual spending through the previous year, divided by annual allowed spending for the year (Table 10-7). For example, to calculate the update adjustment factor for 1997, the difference between the total accrued allowed spending through 1997 and total actual spending through 1996 would be divided by annual allowed spending for 1997. The difference between total allowed spending accrued through 1997 ($104.6 billion) and total actual spending accrued through 1996 ($69.0 billion) is the amount of budgeted spending that remains to be spent for 1997 ($35.6 billion). The update adjustment factor (0.965) is the ratio of the

Table 10-6. Illustrative Growth Rates and Accrued Spending, 1995-2002

Year	Sustainable Growth Rate	Annual Allowed Spending	Total Accrued Allowed Spending	Annual Actual Spending	Total Accrued Actual Spending
1995	-	$33.2	$33.2	$33.2	$33.2
1996	3.8%	34.5	67.7	35.8	69.0
1997	7.2	36.9	104.6	39.1	108.1
1998	7.4	39.7	144.2	41.3	149.4
1999	7.1	42.5	186.7	43.5	192.9
2000	6.9	45.4	232.1	45.8	238.7
2001	6.7	48.4	280.5	48.0	286.7
2002	6.5	51.6	332.1	50.3	337.0

SOURCE: Physician Payment Review Commission analysis.

NOTES: Spending is measured in billions of dollars.

This example assumes that Medicare spending for physicians' services in 1995 will be $33.2 billion, and that the Sustainable Growth Rate system begins in 1996 with an initial conversion factor of $35.42. The example also assumes 2 percent projected real GDP growth per capita and that the system provides an additional allowance of 2 percentage points. In addition, the example assumes 10 percent volume and intensity growth which is reflected in the amounts of actual spending. This growth rate was chosen to illustrate exceeding the lower limit for reductions of 7 percent.

Table 10-7. Illustrative Calculation of the Update Adjustment Factor Under the Sustainable Growth Rate System

Year	(Total Allowed Spending Accrued through Year	–	Total Actual Spending Accrued through Previous Year)	÷	Annual Allowed Spending for the Year	=	Update Adjustment Factor
1997	$104.6		$69.0		$36.9		0.965
1998	144.2		108.1		39.7		0.909
1999	186.7		149.4		42.5		0.878
2000	232.1		192.9		45.4		0.863
2001	280.5		238.7		48.4		0.864
2002	332.1		286.7		51.6		0.880

SOURCE: Physician Payment Review Commission analysis.

NOTES: Spending is measured in billions of dollars.

This example assumes that Medicare spending for physicians' services in 1995 will be $33.2 billion, and that the Sustainable Growth Rate system begins in 1996 with an initial conversion factor of $35.42. The example also assumes 2 percent projected real GDP growth per capita and that the system provides an additional allowance of 2 percentage points. In addition, the example assumes 10 percent volume and intensity growth which is reflected in the amounts of actual spending. This growth rate was chosen to illustrate exceeding the lower limit for reductions of 7 percent.

budgeted amount of spending left for the year ($35.6 billion) and how much spending is projected to occur for the year ($36.9 billion).[8]

Second, to reduce the amount of volatility in the size of the updates for any given year, the update adjustment factor is constrained to increases of less than 3 percent and reductions of no more than 7 percent. In the example, an update adjustment factor of 0.909, equivalent to a 9.1 percent reduction, exceeds the 7 percent limit (Table 10-8). Because the reduction would be limited to 7 percent, the 1998 update adjustment factor would be 0.930.

To derive the 1998 conversion factor update of –4.4 percent, for example, the 2.8 percent MEI would be multiplied by the 0.930 constrained update adjustment factor to obtain the 0.956 conversion factor update.[9]

Potential Limitations of the Proposed Approach

Although the Sustainable Growth Rate system establishes a more reasonable target—and holds to this better than the current VPS system—the proposed approach has some limitations. Two of these would be

[8] The Sustainable Growth Rate system assumes that physicians' actual spending will match target spending each year, thus the annual allowed spending for the year is used as an estimate of projected actual spending for the year.

[9] The conversion factor update can be expressed as a percent, by subtracting 1 then multiplying by 100. In the example, expressed as a formula, this would be (0.956–1)*100 =–4.4.

Table 10-8. Illustrative Calculation of the Conversion Factor Update under the Sustainable Growth Rate System

	Update Adjustment Factor	(Constrained Adjustment	X	MEI)	=	Conversion Factor Update
1997	0.965	0.965		1.029		0.993
1998	0.909	0.930		1.028		0.956
1999	0.878	0.930		1.029		0.957
2000	0.863	0.930		1.028		0.956
2001	0.864	0.930		1.028		0.956
2002	0.880	0.930		1.028		0.956

SOURCE: Physician Payment Review Commission analysis.

NOTE: This example assumes that Medicare spending for physicians' services in 1995 will be $33.2 billion, and that the Sustainable Growth Rate system begins in 1996 with an initial conversion factor of $35.42. The example also assumes 2 percent projected real GDP growth per capita and that the system provides an additional allowance of 2 percentage points. In addition, the example assumes 10 percent volume and intensity growth which is reflected in the amounts of actual spending. This growth rate was chosen to illustrate exceeding the lower limit for reductions of 7 percent.

problematic for any administered price system including the current VPS system. One limitation, however, is technical and could be readily addressed.

First, while the Sustainable Growth Rate system sets a reasonable target based on available information, the target may seem less reasonable with hindsight. For example, projected real GDP growth per capita plus a fixed percentage provides a reasonable target that is in line with the general economy. Substantial changes to the medical marketplace, however, could make the target seem too high or too low. If increased efficiencies in the delivery of care markedly slow volume and intensity growth or if other payers substantially lower their payment levels, Medicare may want to reduce its sustainable growth rate and conversion factor accordingly. Alternatively, if new treatments or diseases or risk selection result in higher volume and intensity growth, it may be appropriate to raise the sustainable growth rate.

Allowing the proposed system to adapt to potential changes in the medical marketplace is difficult because the current budget process makes it hard to increase spending, and any legislative reductions are incorporated into new baseline spending levels. For example, the congressional proposal links the spending target to growth in real GDP per capita plus an allowance of 2 percentage points, while the Administration provides an allowance of 1 percentage point. While the allowance could readily be lowered if it proved too generous, it may be more difficult to increase it. To make the proposed system more flexible, it may therefore be advisable to adopt an allowance of 2 percentage points and to make statutory reductions apply for just one year as needed. In addition, the proposed approach, like the current system, would benefit from continual monitoring of access to care and relative payment levels between the Medicare program and other payers to determine whether the target levels of spending are reasonable.

Another limitation of the proposed approach is that it adjusts the conversion factor annually to recoup all excess or surplus spending that occurred in the prior year. This approach makes the system's conversion factor update more volatile because it not only reflects year-to-year fluctuations in volume and intensity growth, but also recovers the entire excess or surplus in a single year. As a result, the upper limit of 103 percent of the MEI and the lower limit of 93 percent of the MEI are much more important for managing the volatility of annual conversion factor updates.[10] Since the system eventually recovers any excess spending, selecting the size of the limits must consider the amount of payment volatility that physicians' practices can tolerate and how quickly the system recovers excess spending.

The Sustainable Growth Rate system has a third limitation that it shares with the current VPS system. Calculations of the conversion factor update for a given year are based on projections for the MEI and the Part B enrollment rate, excluding Medicare beneficiaries enrolled in risk contracts. Any inaccuracies in these projections will lead to biased conversion factor updates for the year in question, as well as for updates in subsequent years.[11] Over time, more Medicare beneficiaries are expected to enroll in risk contract arrangements. This will make it harder to project fee-for-service Part B enrollment growth. The resulting errors in projection could become substantial, significantly affecting the accuracy of the conversion factor updates.

This limitation could be readily addressed by incorporating an adjustment into the sustainable growth rate that corrects for previous errors in the projection. For example, each year's sustainable growth rate could be based on five factors: inflation, enrollment growth, real GDP growth per capita, changes in spending due to law and regulation, and an adjustment for projection errors made earlier.

COMPARISON OF THE POTENTIAL IMPACT OF THE VPS AND SUSTAINABLE GROWTH RATE SYSTEMS

The Sustainable Growth Rate system would resolve many of the flaws of the current VPS system and differs from it in the following ways:

- establishes a single conversion factor in 1996, and provides a single target and update thereafter;[12]

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[10] Under the Sustainable Growth Rate system, the upper and lower limits are placed on the update adjustment factor.

[11] These projection errors lead to inaccuracies under the current VPS system as well. Performance standards are not readjusted two years later to reflect the most recent estimates of the MEI or Part B enrollment rates before they are used to calculate the conversion factor update for a given year.

[12] The proposed system was expected to begin January 1, 1996. Because this date has passed and the default conversion factors under the VPS system have taken effect, it is unclear what changes might be made to the proposed system in order to implement it midyear or beginning January 1, 1997.

- establishes a target based on growth in GDP per capita instead of a five-year historical trend for volume and intensity growth of physicians' services;

- compares accrued spending since 1995 instead of making year-to-year comparisons and eliminates the two-year delay;

- restricts the size of conversion factor update increases to 103 percent of the percentage change in the MEI and reductions to 93 percent, and accounts for any excesses or surpluses beyond the limits in subsequent years.

Adopting a single conversion factor would have an immediate impact on payment to physicians, because some services would be paid less than before while others would receive more. Changes to how the performance standard and conversion factor update are calculated would also affect physician payment, depending on future rates of volume and intensity growth over time. In this section, simulations of the potential impact of these two systems are presented to illustrate the differences in the VPS and proposed approaches. Because of the sensitivity of performance standards and conversion factor updates to various estimates such as the MEI, GDP growth, and actual volume and intensity growth, these simulations should not be interpreted as forecasts of physician payment under the two systems. Instead, the simulations merely illustrate how these systems would operate under a common set of assumptions.

Impact of Adopting a Single Conversion Factor

As discussed above, the use of separate performance standards and updates for the three categories of services has led to distortions in relative payments. For 1996, surgical services are paid $40.80 per RVU, while primary care services receive $35.42 per RVU and other nonsurgical services receive $34.63. If the VPS system had used only a single performance standard and update since its adoption, the conversion factor for 1996 would have been about $36.63.

Simply adopting a single performance standard and update for future years would not eliminate the differences in payment created in previous years. Each year, the single update would apply to each of the three conversion factors, maintaining permanently the distortion in relative payments. Elimination of this distortion would require adopting a single conversion factor. The Commission, in its *Annual Report to Congress 1995*, suggested adopting a single conversion factor by redistributing payments across categories in a budget-neutral manner gradually over a few years.

The congressional proposal would have established a single conversion factor of $35.42 in 1996. This is the 1996 default conversion factor for primary care services. The Administration would have adopted two conversion factors for 1996, and a single conversion factor thereafter. In 1996, surgical services would receive $38.10, while primary care and other nonsurgical services would receive $35.42.

From an individual physician's perspective, the impact of moving to a single conversion factor would depend on the mix of services the physician provides. Physicians who furnish surgical services primarily

would face larger reductions; those delivering mostly nonsurgical services would have higher payments (Table 10-9). For example, if a single conversion factor of $35.42 were adopted in 1996, payments to thoracic surgeons would be, on average, 8.4 percent lower, while those to cardiologists would rise by 1.4 percent, on average.

Impact of Changes in Formulas for the Performance Standard and Update

Due to the limitations of the current VPS system, physicians may face significant payment reductions regardless of how well they control the volume and intensity of the services they provide. This could occur because physicians are expected to reduce volume and intensity growth 4 percentage points below the historical trend each year. Currently, volume and intensity growth is, on average, about 4.4 percent over the past five years. Under the VPS system, even if volume and intensity growth fell to an average annual rate of 3 percent, the conversion factor would be reduced by about 1.2 percent per year (Table 10-10). This would lead to a conversion factor of about $32.21 in 2005 or—after adjusting for inflation—$25.66 in 1996 dollars (Table 10-11).

Table 10-9. Impact of Change to a Single Conversion Factor from 1995 Conversion Factors, by Specialty (percentage)

Specialty	Percent Change
Medical Specialties	
Cardiology	1.4
Emergency medicine	-2.2
Family/general practice	-1.1
Gastroenterology	1.8
Internal medicine	0.4
Other medical specialties	-1.0
Surgical Specialties	
General surgery	-6.4
Ophthalmology	-6.4
Orthopedic surgery	-7.2
Thoracic surgery	-8.4
Urology	-6.7
Other surgical specialties	-7.1
Other Specialties	
Pathology	2.3
Radiology	2.1
All other specialties	-0.4

SOURCE: Physician Payment Review Commission analysis.

NOTES: The effect of changing to a single conversion factor depends on the mix of services each specialty provides. Specialties, like thoracic surgery that furnish surgical services primarily would have larger decreases than those that provide more nonsurgical services.

Comparisons are made between payments based on a single conversion factor of $35.42 and the 1995 conversion factors for each of the three categories.

Table 10-10. Comparison of Conversion Factor Updates under the Volume Performance Standard System and the Sustainable Growth Rate System for Projections for Volume Growth of 3 Percent, 5 Percent, and 8 Percent (percentage)

Year	Volume Performance Standard System			Sustainable Growth Rate System		
	3 Percent	5 Percent	8 Percent	3 Percent	5 Percent	8 Percent
1997	-0.3%	-2.1%	-2.1%	5.6%	3.7%	1.0%
1998	-2.1	-2.1	-2.1	6.0	1.9	-4.3
1999	-2.2	-2.2	-2.2	4.6	1.1	-3.1
2000	-1.9	-2.1	-2.1	2.2	1.9	1.2
2001	-1.2	-1.3	-1.9	3.8	1.8	-1.1
2002	-1.2	-1.2	-1.2	3.8	1.8	-1.0
2003	-1.2	-1.2	-1.2	3.8	1.8	-1.0
2004	-1.2	-1.2	-1.2	3.8	1.8	-1.0
2005	-1.2	-1.2	-1.2	3.8	1.8	-1.0

SOURCE: Physician Payment Review Commission analysis.

NOTE: This analysis assumes that the Sustainable Growth Rate System begins in 1996 with an initial conversion factor of $35.42. It also assumes that projected real GDP growth per capita is 2 percent and that the system provides an additional allowance of 2 percentage points.

Table 10-11. Comparison of Conversion Factors under the Volume Performance Standard System and the Sustainable Growth Rate System for Projections for Volume Growth of 3 Percent, 5 Percent, and 8 Percent (dollars)

Year	Volume Performance Standard System*			Sustainable Growth Rate System		
	3 Percent	5 Percent	8 Percent	3 Percent	5 Percent	8 Percent
1997	$36.43	$34.68	$35.78	$37.39	$36.74	$35.78
1998	35.66	33.95	35.03	39.64	37.45	34.25
1999	34.88	33.20	34.26	41.48	37.84	33.19
2000	34.21	32.50	33.54	42.40	38.56	33.57
2001	33.80	32.08	32.33	44.02	39.27	33.22
2002	33.39	31.70	31.95	45.68	39.97	32.87
2003	32.99	31.32	31.56	47.40	40.69	32.53
2004	32.60	30.94	31.18	49.19	41.42	32.20
2005	32.21	30.57	30.81	51.05	42.16	31.86

SOURCE: Physician Payment Review Commission analysis.

* These conversion factors are not projections based on current law. To make the systems more comparable in order to better illustrate how they operate, the conversion factor for 1996 under the VPS system was set to $35.42.

NOTE: This analysis assumes that the Sustainable Growth Rate System begins in 1996 with an initial conversion factor of $35.42. It also assumes that projected real GDP growth per capita is 2 percent and that the system provides an additional allowance of 2 percentage points.

Under the current system, increases in the conversion factors can only occur if volume and intensity growth steadily declines over time. If this happened, the historical trend (and hence the performance standards) would fall. Ironically, if volume and intensity grew substantially each year, payments would

drop initially, but the historical trend would rise. With a higher historical trend and performance standards, positive updates would again be possible through reductions in volume and intensity growth.

Under the proposed approach, the sustainable growth rate would not depend on the historical trend. As a result, the conversion factor update would either match or exceed inflation as long as volume and intensity growth equaled or fell below real GDP growth per capita plus 2 percentage points. If volume and intensity growth dropped to 3 percent, the annual update would be about 3.8 percent (Table 10-10). Under this scenario, the conversion factor would be $51.05 in 2005 (Table 10-11). After adjusting for inflation, this would be equivalent to $40.67 in 1996 dollars.

While the proposed approach would provide the potential for increases if volume and intensity growth is sufficiently low, it could result in larger reductions than would occur with the current system. Conversion factor updates would be negative if volume and intensity grew more than 7 percent per year, and reductions would be larger than would occur under the current system if volume and intensity exceeded 8 percent per year. The Sustainable Growth Rate system can provide larger reductions than the current system because the proposed system's limit for penalties is lower than the current one. In addition, the proposed system recoups any excess spending beyond this limit in subsequent years. The current system, however, forgives any excess spending beyond the limit.

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Chapter 11

Managing Medicare's Fee-for-Service Program

Comprehensive restructuring of Medicare should include attention to improving the effectiveness of the traditional fee-for-service program. Recent discussion among policymakers has focused on expanding beneficiaries' access to private health plan options, including managed-care plans. Nonetheless, roughly 9 in 10 beneficiaries are now enrolled in traditional Medicare, with projections suggesting that the majority will remain there in the coming years (O'Neill 1995). Whether or not Medicare is revised through legislative action, Medicare's fee-for-service program may be able to become more efficient by applying some of the same methods that private insurance plans are using to manage care.

Private health insurers are increasingly adopting techniques for managing the delivery of health care within their fee-for-service products. Indemnity insurers are moving beyond their traditional functions of establishing payment rates, processing claims, and maintaining actuarial soundness. Instead, business practices among private insurers increasingly involve methods to analyze and manage both the cost and quality of health care. Profiling providers to identify practice patterns, using case managers for high-cost cases, encouraging adherence to practice guidelines, and implementing sophisticated software tools for screening claims have become mainstream practices. These techniques may determine, in part, both providers' payments and the services that patients receive.

The Medicare program has or is developing its own practices in many of these areas. Traditionally, Medicare has focused on methods for establishing payment, many of which have served as

This chapter includes:

- *Findings from a study of private indemnity plans' care management techniques*
- *Medicare's current use of provider profiling, practice guidelines, case management, and service rebundling*
- *A comparison of Medicare's cost and quality management approaches with those of private payers*
- *Policy directions for strengthening Medicare's management of the fee-for-service program*

de facto industry standards.[1] More recently, Medicare has begun to move in the same direction as private payers, increasing the sophistication of its provider profiling and claims processing techniques, and developing models for the management of care that may be applied within the framework of the Medicare program.

Both private innovation and budget pressures may speed Medicare's adoption of new methods. Private-sector management techniques provide workable models for Medicare. Their increasing acceptance in the private market also makes these techniques more familiar to providers. Constraints on Medicare spending lend a greater sense of urgency to managing the volume of care delivered in the traditional Medicare program.

Identifying potential improvements for the Medicare program requires understanding both current Medicare practice and whether and how experiences in the private sector are relevant to further steps the program could undertake. To some extent, Medicare does not have the same degree of flexibility as private payers. Techniques to manage costs might therefore reasonably be implemented somewhat differently.

Because Medicare now contracts with private health plans for claims processing, these plans may be an important source of information and a convenient testing ground for expanding care management techniques within Medicare's fee-for-service program. Their role should be considered as part of a coordinated effort that allows increased flexibility for innovation. This broader effort would both highlight the important goal of improving Medicare's fee-for-service program and encourage further progress in areas that Medicare is now exploring.

Recommendation

The Health Care Financing Administration should work more intensively with its Part B carriers and Part A fiscal intermediaries to implement the best private-sector practices for managing cost and quality of care within a fee-for-service context. This could include a formal request for proposals from carriers and intermediaries to test promising methods and increased financial flexibility to implement new management techniques.

The first section of this chapter summarizes findings from a Commission-sponsored study of private indemnity plans' initiatives to manage care. It then describes Medicare's current activities in implementing four of the most promising techniques. Next, the chapter contrasts the cost and quality management practices of Medicare and private payers. The final section provides a summary and some policy directions for strengthing Medicare's management of the fee-for-service program.

A SKETCH OF MANAGED INDEMNITY INSURANCE

A recently completed study by the Center for Health Policy Studies (CHPS) provides a sketch of the current state of managed indemnity insurance (Dyckman and Knowlton 1996). This study, funded by the Commission, provides a view of the techniques that 10 private payers were using as of the fall of 1995.

[1] These include, for example, diagnosis-related groups for hospitals and the resource-based relative value scale for physicians.

The study focused on managed indemnity insurance in order to identify approaches that could be adopted by the traditional Medicare program. Accordingly, the study considered only private insurance products that were structured similarly to traditional Medicare, including conventional indemnity insurance and some types of preferred provider organizations (PPOs). An open fee-for-service system like Medicare may not be able to use certain methods adopted by health maintenance organizations and other managed-care arrangements. For example, detailed payment contracts with physicians, tightly restricted networks of providers, or financial incentives placed on beneficiaries would not be feasible within traditional Medicare in the near future.

CHPS identified 10 Blue Cross Blue Shield (BCBS) plans that were known for applying the best available managed-care practices within fee-for-service settings. A combination of surveys and site visit interviews was used to identify care management methods considered most important by these 10 best practice plans.[2] Insights were gathered on the prevalence of these techniques, the plans' assessments of the importance of these techniques for controlling costs or improving quality of care, and how these were being implemented within each plan.

To provide a rough guide to the care management techniques' practical significance, CHPS developed an overall ranking indicator. Actual data on the cost savings realized by these techniques is not readily available. Using the survey results, this ranking combines both the prevalence of the technique—how many plans are using it—and the plans' estimates of the technique's relative importance in controlling costs (Table 11-1).

Table 11-1. Cost Management Techniques Identified in a Survey of 10 Blue Cross Blue Shield Indemnity Plans

Technique	Number of Plans Using Technique	Ranking of Importance to Private Plans*
Case Management	10	3
Practice Guidelines	10	5
Rebundling of Services	10	6
Provider Profiling	9	1
Physician Financial Incentives	8	2
Capitated Carve-outs/Selective Contracting	5	4
Primary Care Physician Gatekeeper	4	7
Bundled Payments	2	8
Patient Financial Incentives to Use Selected Providers	1	9

SOURCE: Dyckman and Knowlton 1996.

* The ranking is based on the number of times an initiative was identified as important and the relative priority given; 1 indicates most important in controlling costs and 9 is the least important.

All or nearly all plans are using provider profiling, case management, practice guidelines, and sophisticated claims editing software. Plans vary significantly, however, in how they implement these

[2] The study did not consider techniques that operate on fee discounts or withholds because Medicare has its own system for establishing physicians' fees.

techniques. There is also much less agreement among plans regarding which additional methods are most promising in their ability to reduce costs or improve quality of care.

Almost all plans profile providers' service use, in some cases to give informational feedback to providers and in others to link utilization to payments or to provider network selection. Provider profiling ranked as the most important technique for cost containment (Table 11-1). Among these plans, provider feedback programs are being used primarily as an educational tool to improve provider practice patterns. Plans vary in their sophistication of techniques used; some plans provide detailed cost reports adjusted for case mix, while others simply tabulate referral and hospitalization rates. Most frequently, plans profile primary care physicians who have gatekeeper responsibilities. They also use profiling in credentialing processes to make decisions about maintaining or dismissing providers on the basis of cost effectiveness.

All plans use case management for high-cost cases, typically for persons with chronic conditions. Case management also ranked relatively high as a cost-saving measure. Under this approach, patients voluntarily agree to have their care coordinated by a case manager who arranges for the provision of care in more cost-effective settings. In addition to benefiting from assistance in coordinating care, patients may gain access to services that are not otherwise covered. Plans identify patients for case management through a variety of means, among them hospital utilization review and discharge processes, referrals by physicians or family, diagnoses, procedures received, or costs accrued. Plans that focus on high-cost cases typically identify these by claims review.

All plans use practice guidelines to some extent, either distributing those developed by the Agency for Health Care Policy and Research (AHCPR) or developing their own based on local medical practices. Plans generally regard guidelines as a way to improve quality rather than a means for achieving short-term cost savings. Consequently, the plans surveyed rarely attach financial incentives to guideline adherence.

All plans use rebundling software programs to edit claims and check for services that should not be billed separately. Rebundling software did not rate as highly as the other techniques in terms of impact on reducing costs, however. Most of these plans use commercially available software as an essential component of claims processing. This software checks for a wide range of billing code combinations that would indicate inappropriate claims such as those with multiple individual codes to describe a single comprehensive procedure or duplicate claims for the same service.

Of the 10 plans surveyed, 8 give at least some physicians a financial incentive to reduce costs or improve patient satisfaction. These financial incentives ranked second to profiling in importance for cost savings. Both positive and negative financial incentives are used; these are tied to provider utilization or cost-based performance measures, such as referral rates or hospital admission rates and costs. This type of incentive is typically applied to primary care physician gatekeepers in point-of-service plans, but several plans use incentive payments for specialist services and within preferred provider organizations as well.

Relatively few of these plans use techniques that restrict patients' access to selected providers.[3] First, only half of the plans contracted selectively for some services. These services typically involve little patient-

[3] This is at least partly because of the study's emphasis on traditional fee-for-service insurance products.

physician contact, such as clinical laboratory services, home infusion therapy, durable medical equipment, and radiology services. Second, fewer than half of the plans use a primary care physician gatekeeper in their fee-for-service products. Primary care gatekeepers are given responsibility to coordinate use of specialty and diagnostic referrals, and are more commonly employed by plans that use tightly restricted networks of providers. Finally, only one plan reported giving patients significant financial incentives to use a selected subset of physicians.

Only two of the plans are working to develop their own bundled payments that assign a single payment rate per episode or admission. These bundled payments generally cover all physician, diagnostic, and facility-based services. Bundling is most often used through selective contracting arrangements made with hospitals for maternity cases and coronary bypass procedures.

MEDICARE'S USE OF COST AND QUALITY MANAGEMENT TECHNIQUES

This section outlines Medicare's current efforts to implement four cost and quality management strategies described above: provider profiling, practice guidelines, case management, and rebundling of services. These techniques may offer the most promise for Medicare in the short term. Their frequent use by the private indemnity payers indicates that they are familiar to providers. In addition, all could be implemented within today's program with minimal use of provider contracts, service limitations, or restrictions on beneficiaries' ability to select providers. In fact, Medicare has incorporated all of these techniques to some degree. The sophistication and comprehensiveness of Medicare's initiatives vary, however, ranging from demonstration projects to integral parts of Medicare's claims review processes.

Provider Profiling

The Health Care Financing Administration (HCFA) and the Medicare carriers, which are private indemnity plans that process Medicare claims, have been implementing profiling approaches to address high utilization rates. Most commonly, profiling processes compare providers' rates of utilization with other similar providers in order to identify outliers in relation to community practice patterns. Over the past few years, HCFA's profiling activities have developed from broad identification of providers with high utilization to more sophisticated analyses. In the past, carriers' postpayment review methods concentrated on examining practice patterns of individual physicians or suppliers. Those providers whose utilization rates scored in the top 5 percent received letters informing them of this situation. Because providers had difficulty interpreting this information and in many cases may have disregarded these letters, this program has been discontinued.

The current profiling process, known as focused medical review, is a multitiered approach. It begins with HCFA's central office examining both specialty-level and procedure-level utilization rates and trends, highlighting differences across carriers. The analyses are then turned over to the carriers for a second level of profiling that focuses on local investigation of the causes of variation both within their area and in relation to other carriers. Receiving general guidance from HCFA, the carriers have a great deal of flexibility in the type of profiling performed and the way they dispense feedback or take corrective actions with providers.

By examining specific services separately and comparing providers with their peers, this process is used to help distinguish causes of rapid spending growth, explain variation in spending within or across states, and identify providers who are driving up expenditures. In some cases, carriers have found that utilization rates for specific services are inexplicably higher in particular geographic areas. In others, specific providers are identified for further action. Carriers then determine an appropriate response. In some instances, providers simply are informed of their practice patterns; in other cases, the carriers may screen a provider's charges either to collect overpayment or to examine claims more closely before payment. In all cases, HCFA instructs carriers to emphasize educating providers.

Although acknowledging this program's potential, the General Accounting Office has identified several limitations in the carriers' efforts to analyze the data and take corrective action (GAO 1994b). Some limitations may raise issues beyond the scope of provider profiling. A claims-based profiling program, for example, is not necessarily designed to address high rates of utilization that exist uniformly across the country. Other issues identified by the study, such as variation in quality of data and results across carriers, are being addressed by HCFA. The agency is also interested in improving efforts to communicate profiling information to providers.

Additional steps could strengthen Medicare's current profiling efforts. For example, adjusting results to account for beneficiary characteristics, such as diagnosis, is useful in interpreting variation in utilization. Further, if practice guidelines could be operationalized as review criteria, profiling could go beyond identifying outliers to more clearly identifying both unnecessary care and lack of necessary care. Profiling that compares providers' patterns of care to those of an accepted practice guideline or standard may reflect the most appropriate practice patterns, but may also be more resource intensive, requiring expanded data capabilities and guideline-based review criteria.[4] HCFA has taken some steps in this area as a component of its quality assurance efforts.

Practice Guidelines

Both the Medicare program and private payers likely benefit from the significant effort made by AHCPR and numerous other public and private organizations in developing and disseminating practice guidelines.[5] Processes used to formulate guidelines vary, but most include literature review and consensus among panels of professionals. Guidelines offer the potential to improve the value of health care in terms of both cost and quality. Practice guidelines can support cost-containment efforts by providing medical decisionmakers with information on the benefits, risks, and costs of a service. This information can in turn promote appropriate medical treatment.

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[4] As a part of its work in monitoring beneficiaries' access to care, the Commission contracted with RAND to develop a set of clinical indicators that identify services representing necessary care for a given diagnosis (PPRC 1995b). Claims data are used to determine the extent to which Medicare beneficiaries receive those services.

[5] The Commission has previously suggested methods for AHCPR to enhance its efforts to facilitate the use of its guidelines in practice (PPRC 1995a). Observing that guidelines offered the most potential to influence practice patterns when they were implemented under a system that can provide incentives for compliance, the Commission recommended that AHCPR focus its guideline development on topics that would be useful to organized groups of providers and systems of care. The Commission also recommended increasing the agency's efforts to develop review criteria that can be used to measure compliance with the guidelines and to support the development of tools that help providers and beneficiaries comply with a guideline.

Medicare has adopted a number of approaches for using practice guidelines to improve quality of care (Gagel 1995). While the program does not develop its own guidelines, it has distributed AHCPR guidelines on pain management, pressure ulcer treatment, depression in primary care, and urinary incontinence to nursing homes. Medicare's peer review organizations (PROs), the contractors responsible for ensuring appropriateness and quality of care, have also recently begun to develop quality review criteria based on practice guidelines. Using claims data, the PROs compare provider profiles with guideline specifications, identify existing variations, and distribute these data to physicians and hospitals for their analysis and use.

Practice guidelines have been primarily used by the Medicare program as a means to ensure quality rather than to determine payment. Medicare carriers do consider AHCPR practice guidelines along with other literature in determining medical necessity for payment. But because the agency's guidelines have so far centered on treatment for conditions rather than on appropriate indications for services, the guidelines are not ideally suited for this purpose.[6]

Using guidelines for payment determination requires consideration of several additional issues. First, the information necessary to fully examine compliance with guidelines may not be available from claims data, requiring use of medical records. For example, detailed information on patient characteristics would be important for evaluating agreement with guidelines. Another consideration is provider accountability. Because many treatments involve several providers, it may be difficult to pinpoint responsibility for care. Further, there are apt to be specific circumstances in which appropriate care may not correspond to guideline criteria. This could lead to complicated payment appeals processes.

Case Management

The term "case management" is used quite loosely to describe a variety of different approaches to reducing costs through coordination of care. For example, case managers may be nurses who offer patients diagnosed with costly conditions additional home care services as an alternative to a more lengthy hospitalization. On the other hand, some case managers do not begin contact with high-cost patients until after they are home, focusing more on continued surveillance to avoid rehospitalization. Case management is also used to describe a significantly different management style that uses primary care physicians to furnish primary care services, coordinate care, and serve as gatekeepers for more specialized services.

Medicare has dealt with the different approaches in separate ways. Some efforts to introduce case management have been on a demonstration basis, providing resources to an organization with the sole responsibility of coordinating care for beneficiaries with selected diagnoses that often lead to high medical costs.[7] Case management interventions in the early 1980s, referred to as channeling demonstrations,

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[6] One exception is coverage for cataract surgery. HCFA regulations encourage the use of AHCPR cataract guidelines in determining medical necessity.

[7] Case management was also an important component of Medicare's social HMO demonstrations that focused on increasing access to care for frail elderly populations.

intended to reduce spending for frail elderly beneficiaries by substituting home and community-based services for nursing home care. Evaluations of these programs found that they did not reduce spending, however, because they did not successfully target people who would have entered nursing homes in the absence of the intervention (Schore et al. 1995).

Under the Medicare Case Management Demonstrations mandated by the Omnibus Budget Reconciliation Act of 1990, three organizations were involved in projects to provide case management services to Medicare beneficiaries identified to be at risk of high-cost care. Following a nine-month planning phase, these demonstrations operated from October 1993 through September 1995. Case management for the demonstrations included providing condition-specific education and arranging for support services. Most of the contact between beneficiaries and case managers was by telephone. Eligible beneficiaries were identified based on medical diagnoses, including congestive heart failure and other chronic conditions, and were approached to take part in the demonstration either while hospitalized or through the mail after being discharged. Their participation in the program was voluntary.

The final report on these demonstrations, which will assess their effectiveness in identifying high-cost beneficiaries and reducing the costs of their care as well as improving the quality of care, is not yet available. The report is also intended to identify and critique alternative methods of paying for case management under Medicare. Interim results report less success than was anticipated, however. The programs encountered considerable apprehension from physicians and beneficiaries, causing more time-consuming beneficiary enrollment processes and lower consent rates than expected (Schore et al. 1995).

HCFA is exploring other case management approaches for Medicare that distribute bundled payments to a provider or group of providers to create incentives to more efficiently direct beneficiaries to appropriate specialty care (HCFA 1995). Under this type of approach, a primary care physician would provide comprehensive management for beneficiaries with specific diagnoses such as diabetes, hypertension, congestive heart failure, or dementia with one or more comorbidities. Medicare would reimburse providers with a bundled, capitated payment in a similar manner to that currently done for end stage renal disease (ESRD). This ESRD policy provides payment on a monthly basis. HCFA is seeking feedback on the types of patients that would benefit from this type of case management and the appropriate time period for basing payments.

Case management will also be a component of other demonstration projects that HCFA is planning. For example, evaluation of an upcoming Group Volume Performance Standard demonstration will examine case management strategies used by provider groups. Additionally, HCFA is launching Medicare Choices, a demonstration that will offer beneficiaries a broad range of health care delivery options that manage care. These options will likely include some primary care case management models that use a primary care gatekeeper to coordinate and monitor specialty services. Final decisions on which proposals will be funded have not yet been announced.

Rebundling of Services

Identifying billing codes that most accurately describe actual services rendered may be difficult for providers. The fee-for-service payment approach, whereby providers submit claims for individual services

performed, leaves open the potential for honest mistakes as well as fraud and abuse. Such discrepancies can lead to overpayment.

One common error involves unbundling, or billing for two or more codes to describe a procedure when a single comprehensive (bundled) code exists. For example, although the fee for removing a ruptured appendix includes payment for making the incision, closing the wound, and removing the appendix, separate codes exist for all three components. Another similar error involves bundled payment codes for major procedures that include related follow-up services within a specified time period. In some cases, providers may bill separately for the comprehensive procedure and the additional followup care.

HCFA has been enhancing its ability to detect inappropriate use of billing codes prior to payment. It recently used a private contractor to identify a comprehensive list of combinations of specific Medicare codes that should not be billed together. HCFA then adjusted the list to incorporate comments from the provider community. In January 1996, carriers fully implemented the edits to detect these combinations and automatically adjust payments accordingly.

ADAPTING PRIVATE-SECTOR MANAGEMENT TECHNIQUES TO MEDICARE

This section examines specific ways in which Medicare's approaches to provider profiling, case management, and service rebundling differ from those of private payers. Activities in these three areas illustrate many of the ways in which Medicare's unique structure affects the approaches to cost and quality management it can use or how they are implemented. Along with legislative requirements, payment and coverage policies must be considered when adapting private-sector management techniques to Medicare. Additionally, as a public program, Medicare has both formal and informal procedures for accountability that can entail consultation with beneficiaries, providers, the Congress, and others, as well as formal notices of proposed rulemaking. These factors may all bear not only on the implementation methods pursued, but also on the cost and quality results achieved.

Provider Profiling

The data collection and analysis aspects of profiling strategies seem to be quite similar for both Medicare and private payers in many respects. Medicare may in fact have an advantage over some private payers in identifying and addressing causes of high-cost care, particularly because of its ability to draw on the rich Medicare claims data source.

Private payers have a greater capacity to move beyond educational activities, however, to modify provider payments or participation criteria based on profiling analyses. This distinction may be important because, although feedback of profiling results can improve provider performance, it can be more effective when used in combination with some type of incentive (Schoenbaum and Murrey 1992). While private plans are free to use profiling results to reward providers financially or to exclude providers from their select

provider networks, Medicare may exclude providers only in proven cases of fraud and abuse.[8] This limits Medicare's ability to select networks of providers. Additionally, because Medicare's fee schedule mechanism does not allow payment differentials across physicians, financial incentives may not be offered as part of provider profiling activities.

Case Management

Medicare's experience with case management highlights several ways in which Medicare payment and coverage policies influence implementation of these techniques. One basic issue is that Medicare generally is not able to pay for case management under the Medicare Fee Schedule reimbursement system. Private payers often have flexibility in their ability to distribute payments to case managers. Frequently, they pay staff nurse case managers on a salaried basis. Medicare has found methods to pay for case management within its constraints, yet it has not been able to fully incorporate it into the program. To date, Medicare's case management activities have been implemented either through demonstration programs or by defining limited payment policies.[9]

A great deal of uncertainty surrounds the cost saving potential of case management programs. Their popularity and continued use in the private market suggest that plans serving that market believe that case management can save money. Survey results from the CHPS study further support this belief. Nonetheless, Medicare case management demonstrations have not yet shown direct cost savings.

One possible explanation for this inconsistency is that existing payment policies may interact with case management's cost-saving techniques. For example, case management in the private sector may put greater emphasis on shortening the length of a hospital stay by making home care more feasible. By providing fixed payments to hospitals based on diagnosis-related groups (DRGs), however, Medicare already has established an implicit incentive to control hospital stays. Further savings are therefore not directly achieved by this means. In fact, Medicare costs may actually increase if the patient requires additional care after being discharged.

Cost savings from case management may also depend on the payer's flexibility in modifying coverage policies. For example, private payers may be able to encourage patient participation in case management activities by offering them services or equipment not normally part of the benefit package. To encourage beneficiaries' participation, Medicare may need greater flexibility in restructuring benefits than is permitted under current coverage policies.

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[8] This policy is determined by a combination of several sections of the Social Security Act: Section 1801 prohibits federal interference in the practice of medicine, Section 1128 specifies the conditions under which providers can be excluded from Medicare, and Section 1802 specifies that Medicare beneficiaries may obtain care from any qualified provider.

[9] Medicare has begun to provide reimbursement for some care oversight under Current Procedural Terminology code 99375. This is a monthly case management fee for physicians who spend more than 30 minutes per month managing patients' home health or hospice care. Use of this code has increased from 187 allowed services in 1994 to over 820,000 services in 1995. More than three-fourths of these payments are received by physicians specializing in general practice, family practice, or internal medicine (HCFA 1996).

A final concern is that the Medicare case management demonstrations may not have been implemented in a manner that would most effectively achieve cost savings. Evaluation of early case management demonstrations highlighted the importance of screening for cases with high costs that could potentially be reduced. More recent demonstrations have confronted the need for better screening, but encountered other difficulties such as gaining providers' support and cooperation. Offering financial incentives to providers for accommodating case management recommendations might address these shortcomings.

Rebundling of Services

Differences between Medicare's and private payers' standards for denying claims could reflect program accountability as well as the technical rebundling process. Some have questioned whether HCFA's approach to developing its own rebundling policies can be as efficient in detecting inappropriate billing codes as the commercial rebundling software used by private payers (GAO 1995a). The independent process pursued by HCFA may best suit Medicare, though, both because of its specific payment policies and the requirement to involve those affected by claims denial decisions in policy development.

Policies to improve the accuracy of claims review can also be affected by financial accounting processes. Because funding for administrative management of the Medicare program is assigned to a separate account from funding for provider payments, shifting resources from one area to another requires legislative appropriation action. Medicare therefore may have less flexibility than private payers to quickly administer policies expected to yield overall cost savings. In fact, despite documentation that Medicare can save substantial benefit dollars by increasing spending for activities such as claims review, resources appropriated for these operations have actually decreased in recent years (GAO 1994a).

Unlike most private payers, HCFA is moving beyond efforts to enforce proper payment for bundled services by developing new bundles that provide a single comprehensive reimbursement for a group of related services. Such bundled payments could be constructed to give providers incentives to manage care. The classic example may be Medicare's DRG payments. Medicare is experimenting with other payment policies primarily under demonstration projects. The program has identified several centers of excellence, which receive bundled payments for the hospital and physician services involved in cataract and coronary bypass surgeries. HCFA will soon extend these demonstrations to other surgical procedures and is also exploring ways to use a similar bundled payment approach for other types of care, including primary care case management.[10]

STEPS FOR IMPROVING FEE-FOR-SERVICE MEDICARE

While the current policy discussion has focused primarily on expanding managed-care options, the importance and potential of fee-for-service insurance in both Medicare and the private sector should not be

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[10] Through demonstrations and other projects, Medicare also has been exploring payment mechanisms for other types of care management initiatives. Among these endeavors are adjusted payments for high-cost medical staffs, ambulatory patient groups for outpatient services, lump sum per case payments to combine reimbursement for Part A and Part B Medicare services, medical group practice Volume Performance Standards, and competitive bidding for high-volume items.

underestimated. Even as managed care grows, private indemnity insurers and the traditional Medicare program are working to improve their management and delivery of care.

Examination of the best private practices may suggest areas where traditional Medicare can improve. In some areas such as profiling, Medicare's activities parallel typical private practice, while in others such as case management, Medicare's efforts have not progressed beyond demonstrations.

Medicare's ongoing efforts to improve its fee-for-service operations might benefit from being drawn together in a coordinated initiative. Similar to the Medicare Choices demonstration for Medicare managed care, a traditional Medicare initiative could add significant visibility to current efforts and serve as a vehicle for highlighting and clarifying the strategic goals for the traditional Medicare program.

As a first step in this direction, Medicare could turn to its Part B carriers and Part A fiscal intermediaries. These entities play a unique role as insurance companies that are aware of both private and Medicare practices. Although HCFA already works informally with these contractors to advance demonstrations and develop innovations, a formal request for proposals on ways to integrate the best private practices into Medicare would be a good way to start a new initiative. This would provide a ready source of information on details of implementation and offer carriers a modest incentive to adapt private practices into approaches that are workable within the Medicare program.

To implement novel techniques, Medicare may need more flexibility in its methods for paying providers. As noted above, private payers have a much greater ability to link profiling to payment and to arrange innovative payment methods for case management. Greater selectivity in whom Medicare pays could also increase Medicare's efficiency (Etheredge 1995; GAO 1995b). While any fundamental changes should be approached with caution, modest changes in payment methods may be needed to allow Medicare to keep up with the best practices of private indemnity payers.

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Monitoring Access and Financial Liability for Medicare Beneficiaries

Medicare was created to help ensure access to health care services and to provide financial protection for beneficiaries. The Commission's monitoring of beneficiary access and financial liability allows the Congress to assess the extent to which Medicare is achieving these objectives.

To conduct its monitoring, the Commission analyzes claims, survey, and other data and prepares annual reports for the Congress. The Commission also comments on two reports from the Secretary of Health and Human Services—one on utilization and access to care and one on beneficiary financial liability—called for under the Omnibus Budget Reconciliation Act of 1989 (OBRA89).

Detailed Commission reports on beneficiary access and financial liability will be issued in mid-1996. This chapter foreshadows those reports and presents highlights of some early analyses of the most recent data available. The access section looks at evidence of whether Medicare payment rates are adequate for the purchase of needed services and whether there appear to be local "hotspots" of access problems for beneficiaries. The forthcoming access report will also focus on access to care for vulnerable groups of beneficiaries.

The financial protection section of this chapter updates information on assignment rates and the percentage of physicians participating in Medicare. Progress toward compliance with Medicare charge limits is also noted. The forthcoming financial liability report will provide further details on these issues.

This chapter includes:

- *Analyses of access as reported by beneficiaries*
- *Analyses of data on beneficiary use of services*
- *Comparison of Medicare and private physician payment rates*
- *Results of a study of hotspots of poor access*
- *Update on beneficiary financial liability*

ANALYSIS OF ACCESS

In its monitoring work, the Commission has defined beneficiary access as the ability to obtain needed medical care. A number of access barriers that may affect beneficiaries' ability to obtain needed services have been discussed in the health care literature (Aday and Andersen 1981; IOM 1993). Some barriers, such as education, income, and language, are patient-related. Others, including the number and distribution of providers, financing of care, and the availability of transportation, involve the structure and organization of the health care system. Although any of these barriers may influence beneficiary access, the analyses presented here address barriers to access related to changes in Medicare physician payments.

To date, the Commission's monitoring efforts have focused primarily on identifying any changes in access that could have resulted from enactment of physician payment reform in 1989. These efforts have shown that access appears to be good for most beneficiaries. Information from beneficiaries shows that few have had trouble getting care and most are satisfied with the care received. Medicare claims data show no systematic drop in service volume where payment levels have been reduced. An exception to these findings is that information on beneficiary complaints about access, collected by the Commission for previous reports, suggests that beneficiaries sometimes have difficulty finding a new physician after they move or their current physician retires.

Vulnerable populations who experienced access problems before the Medicare Fee Schedule was introduced in 1992—African Americans, those in urban poverty areas, and those in urban Health Professional Shortage Areas—continue to experience restricted access. Evidence of limited access includes low use of primary care services, high use of emergency rooms, and high mortality rates. The range of access problems these vulnerable beneficiaries experience suggests that a multipronged approach must be pursued to solve them.

In its 1995 annual report, the Commission recommended that multiple approaches be considered to maintain and expand service delivery for underserved Medicare beneficiaries. These approaches include (1) ensuring appropriate numbers and distribution of health professionals to serve these beneficiaries; (2) paying providers, including qualified nonphysician health professionals, who care for these beneficiaries; and (3) making certain that these beneficiaries have access to new health care delivery systems.

As the Medicare program continues to evolve, methods for monitoring access must do so as well. Growth in beneficiary enrollment in managed care, for example, has prompted the Commission to develop a work plan for monitoring Medicare health maintenance organization (HMO) enrollees' access to care (PPRC 1995c). Such efforts are aimed at improving the Commission's monitoring capability and testing methods for use in the Medicare program. Further plans for monitoring access that recognize Medicare program changes are discussed at the end of this chapter.

Studies of access are limited by the difficulty of distinguishing between needed and unneeded services.[1] Ideally, the Commission would like to be able to measure beneficiary access to the services needed to

[1] A more extensive discussion of measuring access to needed services appears in the Commission's 1994 report *Monitoring Access of Medicare Beneficiaries* (PPRC 1994).

improve health outcomes. Since currently available data do not distinguish between appropriate and inappropriate services, the Commission looks for evidence of potential access problems from multiple perspectives with the different types of data that are available. To the extent it finds such evidence, the Commission then judges whether Medicare beneficiaries appear to be experiencing decreased access to appropriate services and whether policy changes are warranted.

Several analyses of access are presented below. First, the most recent results available from the Medicare Current Beneficiary Survey (CBS) are reported. These include measures of access, satisfaction, and quality of care as reported by beneficiaries. Second, analyses of beneficiary use of services, based on Medicare claims, are updated with data from the first six months of 1995. Third, the latest work comparing Medicare and private payment rates is presented. Finally, the results of a survey of particular areas that may have poor access, or hotspots of access problems, are discussed.

Access as Reported by Beneficiaries

Beneficiary perceptions of access to care are addressed by the Medicare Current Beneficiary Survey. The CBS is a longitudinal survey providing information on specific aspects of beneficiary access to care, such as reasons for difficulty in finding a physician, whether care was delayed for financial reasons, availability of a usual source of care, and satisfaction with care. This important data source provides useful contextual information that complements analyses of utilization patterns.

This section describes the CBS and presents analyses of several key questions. Additional analyses, focusing on access for vulnerable populations, will be prepared for the Commission's access report.

Description of the Survey. The CBS, which began in 1991, is a longitudinal survey of about 12,000 Medicare beneficiaries. The core survey and its supplements, sponsored by the Health Care Financing Administration's (HCFA) Office of the Actuary, include information on utilization of services, expenditures, health insurance coverage, access to health care services, satisfaction with care, health status, and physical functioning, as well as demographic information.

The CBS sample was constructed to be representative of the Medicare population as a whole. The oldest-old (over 85) and the disabled under 65 were oversampled because the sample size would otherwise be too small to draw policy and research conclusions about these populations. Additional beneficiaries are added each year to replace those no longer in the sample because of death, emigration, or refusal to participate. These supplemental samples include both newly and previously enrolled Medicare beneficiaries.[2]

Access to Care, Satisfaction, and Quality of Care. Beneficiaries were asked directly and indirectly about their access to care. Questions such as whether the respondent had ever had a medical problem but did not see a physician and whether the beneficiary had a particular physician or physician's office as his

[2] About 8 percent of those in the CBS sample were institutionalized at the time of the survey. Since responses to some questions are not available for these beneficiaries, they were excluded from the analysis.

or her usual source of care are considered direct measures of access. In instances where beneficiaries had problems with access to care, reasons for these problems were elicited.

Patient satisfaction and perceptions about quality are considered indirect indicators of access. It is assumed that when barriers to care exist, beneficiaries will express dissatisfaction with the care provided. Indirect measures considered here include satisfaction with the availability of care at night and on weekends, beneficiaries' confidence in their physicians, and perceptions about the quality of their care.

Analyses of the 1994 survey show that measures of access to care are essentially unchanged from previous years, and that access for most beneficiaries remains excellent. About 86 percent identified a physician's office as their usual source of care or, if they obtained care in another setting, saw a particular physician (Table 12-1). Among those without a usual source of care, most saw no need since they were seldom or never sick. Furthermore, 96 percent reported no trouble getting care during the past year. Among those reporting trouble, cost and transportation were the most commonly cited problems.

Table 12-1. Medicare Beneficiaries Reporting Acceptable Access to Care, 1994 (percentage)

Survey Question	Beneficiaries with Positive Response
Access to Care	
Usual source of care in office or with particular physician	86%
No delayed care due to cost during past year	89
No trouble getting care during past year	96
Satisfaction with Care	
Satisfied with availability of care at night and on weekends	93
Satisfied with ease of getting to physician	93
Satisfied with out-of-pocket costs paid for medical care	83
Has great confidence in physician(s)	94

SOURCE: Physician Payment Review Commission analysis of the 1994 Medicare Current Beneficiary Survey.

NOTE: This analysis excludes institutionalized beneficiaries.

Satisfaction with care also remained high. At least 93 percent had great confidence in their physician, and were satisfied with the availability of care at night and on weekends as well as with the ease of getting to a physician. Although satisfaction with out-of-pocket costs was lower than that with access and quality, it was still fairly high at 83 percent (Table 12-1). Only 0.2 percent of beneficiaries reported having problems getting care because the physician would not accept Medicare patients.

Changes in Beneficiary Use of Services

In addition to monitoring measures of access, satisfaction, and quality of care with survey data, the Commission monitors changes in beneficiary use of services with Medicare claims data. If beneficiaries

are experiencing access barriers, these barriers may be revealed by reductions in use of services. From a payment policy perspective, use of services that have undergone payment rate reductions is of particular importance. Medicare claims files are a large store of information on beneficiary use of services. Timely updates of the files by HCFA make it possible to detect access problems as they emerge.[3]

Methods. To analyze changes in utilization, Medicare beneficiaries' service use during the first half of 1995 was compared with service use during the first six months of 1994. The trend from 1992 to 1995 was also computed. Data consisted of all physicians' services claims for a 5 percent sample of beneficiaries.[4]

Two measures of service use were calculated as part of the claims analysis. First, simple counts of services were tabulated. These counts do not reflect changes in the mix of services from, for example, less complicated to more complicated procedures. Second, an index of the total volume and intensity of care was created. To construct this index, counts of services are weighted in proportion to the payment rate for the service. For example, a $1,000 cataract surgery would be weighted as heavily as 10 consultations costing $100 each. This index captures changes in the count of services as well as changes in the mix, or intensity, of services.[5] In general, the volume and intensity index measures change more accurately than counts of services.

In its previous work with utilization data, the Commission found that changes in use of services must be interpreted carefully when assessing the relationship between service use and access to care (PPRC 1994). Factors such as changes in technology or medical practice often explain changes in service use that do not necessarily involve changes in access to care.

Results. Overall beneficiary use of physicians' services continued to climb through 1995. The volume and intensity per beneficiary of all services rose by 5.2 percent between 1994 and 1995 (Table 12-2).

Changes in volume do not appear to be correlated with payment rate changes (Table 12-2). Between 1994 and 1995, payment rates for primary care increased by 9.1 percent, and use of these services grew by 5.2 percent. Payment rates for other nonsurgical services fell slightly by 0.2 percent, and the use of the services grew by 6.3 percent.

While service use generally increased, use of two specific services—transurethral prostate surgery and open prostate surgery—decreased between 1994 and 1995 (Table 12-2).[6] Volume and intensity changes for those services were, respectively, –1.1 percent and –8.7 percent.

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[3] The Commission is able to analyze 1995 claims for this report because of the National Claims History system developed by HCFA. Through a significant effort on the part of HCFA's Bureau of Data Management and Strategy staff, the Commission now receives a sample of half-year claims data in the fall of the same year in which the claims were submitted.

[4] Further details on the Commission's analyses of Medicare claims data are provided in *Monitoring Access of Medicare Beneficiaries* (PPRC 1995c).

[5] Volume and intensity growth is measured by asking how much outlays would have risen if prices had been frozen. This is computed directly from data on individual services, calculating the total cost of 1995 services at 1994 prices, then comparing this to actual 1994 outlays.

[6] The decrease in mammography volume between 1992 and 1995 was addressed previously (PPRC 1994). The combination of a volume decrease and an increase in the count of services reflects a change in procedure coding practice accompanying extension of Medicare coverage to include screening mammography.

Table 12-2. Change in Payment and Use per Beneficiary for Selected Services, 1992-1995 (percentage)

Type of Service	Annual Percentage Change 1992-1995 Payment per Service	1992-1995 Volume[a]	1992-1995 Count of Services[b]	1994-1995 Payment per Service	1994-1995 Volume[a]	1994-1995 Count of Services[b]	Percentage of 1995 Physician Services Outlays
All Services	2.8	5.1	4.8	3.9	5.2	3.7	100.0
Primary Care Services	6.9	5.1	4.3	9.1	5.2	4.1	21.2
Office and other outpatient visits	6.2	4.0	3.7	8.5	3.9	3.3	16.4
Emergency department	9.0	10.4	8.6	10.9	7.1	4.3	2.5
Nursing facility/rest home	10.8	8.7	7.1	11.5	7.9	6.2	1.9
Home visits	10.7	5.5	4.9	11.9	6.7	6.3	0.2
Other Evaluation and Management Services	5.4	6.0	3.5	6.7	2.1	-0.5	17.5
Surgical Services	2.8	3.3	6.8	4.7	5.8	9.0	21.9
Cataract lens replacement	-1.1	-0.3	-0.3	-1.5	6.9	7.0	3.3
Joint prosthesis	2.2	6.0	5.5	3.3	7.4	7.0	1.4
Coronary artery bypass graft	2.6	6.5	7.4	5.9	11.4	11.0	1.3
Transurethral prostate surgery	5.6	-11.2	-10.9	9.1	-1.1	-1.1	0.4
Arthroscopy	1.6	8.6	8.4	2.5	7.3	7.3	0.2
Open prostate surgery	5.0	-14.7	-14.0	8.3	-8.7	-7.8	0.1
Other Nonsurgical Services	-0.2	5.8	5.0	-0.3	6.3	4.0	39.3
Diagnostic radiology, other	0.2	1.4	1.8	1.7	1.5	1.7	3.2
Electrocardiograms	--[c]	--[c]	--[c]	3.7	6.3	8.3	2.1
Echocardiograms	-5.1	14.4	14.8	-8.7	2.5	-2.1	1.9
CAT scans	-0.1	4.0	5.1	1.0	5.2	6.6	1.5
Colorectal endoscopy	-0.8	3.3	-1.3	0.4	0.5	-3.1	1.4
Upper GI endoscopy	-4.2	4.8	3.5	-4.8	4.6	3.4	1.0
Magnetic resonance imaging	1.6	12.0	12.4	3.2	9.7	12.0	1.0
Angioplasty	-6.5	11.6	11.5	-7.5	10.8	10.7	0.6
Mammography	1.1	-0.7	1.8	1.8	2.5	6.2	0.4

SOURCE: Physician Payment Review Commission analysis of 1992-1995 Medicare claims, 5 percent sample of beneficiaries.

[a] Measures change in outlays if prices were frozen (volume and intensity).

[b] Measures change in the number of services only.

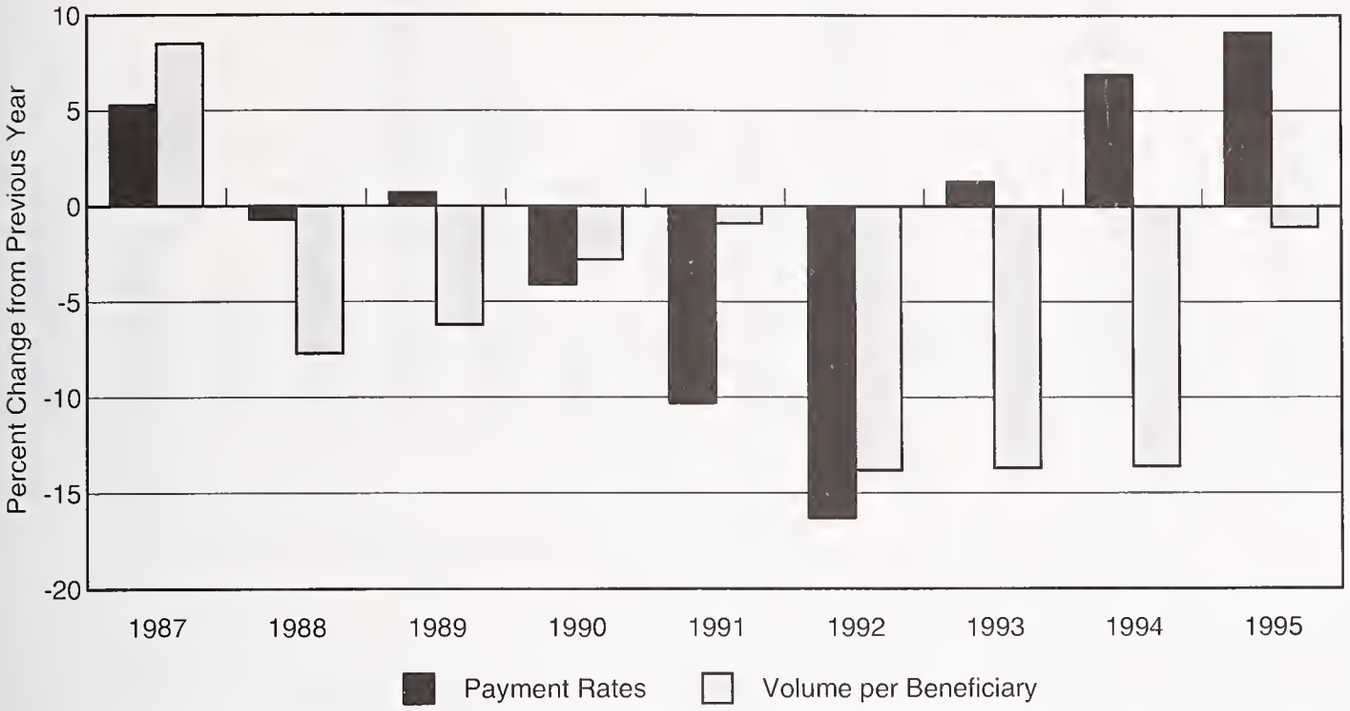
[c] Not applicable due to payment change.

NOTE: Data are for the first six months of each year.

The reductions in use of prostate surgery appear to be a continuation of trends driven by technological change rather than by reductions in access. Data show that decreases in use of transurethral prostate surgery, for example, started in 1988 (Figure 12-1). The decreases have continued despite payment rate increases from 1993 through 1995. The emergence of alternatives to surgery, such as watchful waiting, drugs, and other procedures, is believed to be influencing the

trends in prostate surgery (PPRC 1994). Other services have experienced decreases in use because of changes in technology.[7]

Figure 12-1. Change in Payment Rates and Volume per Beneficiary, Transurethral Prostate Surgery, 1987-1995



SOURCE: Physician Payment Review Commission analysis of 1986-1994 Medicare claims, 100 percent summary file, and 1995 Medicare claims, 5 percent beneficiary file.

The 5.2 percent growth rate in use of all services is lower than the trend seen before the Medicare Fee Schedule was introduced (Figure 12-2). It is higher than rates during the first three years of fee schedule implementation, however. The annual growth rate for the five years ending in 1991 was 7.1 percent, while the average annual rate for 1991 to 1994 was 3.8 percent, the lowest rate since the mid-1980s. Because volume and intensity growth has been quite volatile, interpretation of the 1994 to 1995 change is difficult. During the 10 years ending in 1991, annual growth rates ranged from 3.7 percent to 10.3 percent.

Medicare and Private Payers' Rates

To maintain access to care, Medicare's payment rates need to be adequate to purchase needed services for beneficiaries. Comparing Medicare and private rates provides information on Medicare's relative financial attractiveness to physicians.

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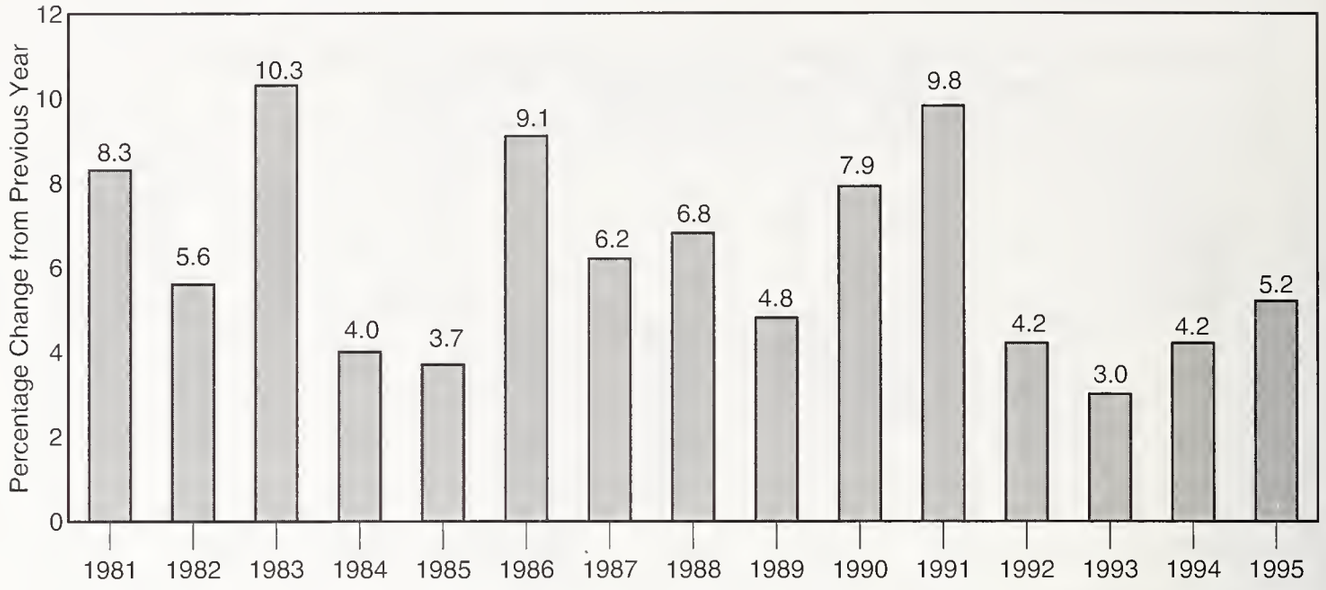
[7] Cataract lens replacement was cited in the 1994 access report as another procedure in which technology has influenced utilization patterns. With lens replacements, technology made a new group of patients candidates for the procedure in the early 1980s. Depletion of this pool of new patients over time appears to have precipitated the fall in volume growth seen in 1993. The decrease in use of cataract lens replacements in 1993 has been followed by positive growth rates in 1994 and 1995.

Figure 12-2. Change in Service Volume and Intensity per Beneficiary, 1981-1995 (percentage)



SOURCE: Physician Payment Review Commission analysis of 1991-1995 Medicare Claims, 5 percent sample of beneficiaries; Board of Trustees 1995.

Surveys show that physicians' main source of dissatisfaction with Medicare is low payment rates (Emmons 1994). But the Commission has found no systematic link between Medicare payment rates and access to care so far. This suggests that Medicare rates, while low by private standards, currently provide adequate financial compensation for physicians to serve Medicare patients.

From 1989 through 1992, Medicare payment rate restraints widened the gap between Medicare rates and those of the average private payer. From 1992 to 1996, however, higher Medicare payment rate updates and rapidly falling inflation in private rates have brought the gap back to the level that existed in 1989. A number of factors are believed to be contributing to the decline in private rates, including competition among health plans, a surplus of physicians, and private payer adoption of payment policies similar to those of Medicare. The Commission's current projection is that Medicare's 1996 physician payment rates average roughly 71 percent of typical private payer physician payment rates.[8]

Speculating on the future of Medicare and private rates is difficult. Medicare's 1996 update was nearly zero, and low updates are likely for the near future. But private payers are also experiencing low or negative payment rate inflation, with annual private payment rate increases declining from a 4 percent increase in 1990 to a more than 1 percent decrease in 1994. The net impact of these changes is not clear.

The first part of this section describes the data and methods used to develop an estimate of national average private payer physician payment rates. The second part of the section presents the Commission's projection for 1996 payment rate levels. Finally, the section looks at the issue of variation in payment rates

[8] The projected 1996 gap of 71 percent should be compared to a revised 1995 estimate of 70 percent discussed later, not to last year's projection of 68 percent.

across areas, payers, and services, raising the question whether other approaches would be more useful than looking at national average data.

Methods. A detailed description of the methods used to estimate national average private payer physician payment rates was presented in the Commission's *Annual Report to Congress 1995* (PPRC 1995a). Briefly, the Commission takes payment information from a variety of indemnity and preferred provider organization (PPO) data sources to create a private indemnity/PPO payment rate index. This index is then adjusted downward to account for fee-for-service payments from HMOs, based on an estimate of typical HMO payment rate levels and HMO shares of physician practice revenues. The end result is an estimate that should reflect typical private payment rates for physicians' services, weighting payers, services, and geographic areas to reflect their overall share of physician practice revenues.

This year there were modest changes in data and methods, resulting in both revised historical data and a projection of payment rates for 1996.[9] First, indemnity and PPO claims showed a 1 percent drop in average payment rates from 1993 to 1994. This was consistent with prior available data showing inflation falling from 4 percent in 1990 to zero in 1993. Last year, a zero percent rate of private payment rate inflation was projected for 1994 and 1995. Now, the 1994 estimate is revised to reflect actual data, and a further 1 percent per year drop is assumed for 1995 and 1996.

Second, surveys show HMOs accounting for an increased share of physicians' practices (AMA 1995). In last year's projections, fee-for-service payments from HMOs accounted for 22 percent of physicians' private payment revenues based on 1993 survey data. The share of revenues from HMOs rose to 27 percent in 1994. As with the payment rate data, the HMO revenue share increase results in both a revised 1994 estimate and an assumption that the HMO share of physicians' private insurer revenues continued to climb by 5 percentage points per year in 1995 and 1996.

Third, there is considerable uncertainty about the level of typical HMO payment rates. Last year's estimate was based on a Commission survey of managed-care plans. Using information on plans that paid on a relative value scale suggested that the typical HMO paid only slightly less than the typical Blue Cross Blue Shield plan, or roughly 135 percent of Medicare rates. This year, a lower estimate of 120 percent of Medicare rates is being used based on conversations with industry experts.[10]

Finally, Medicare's actual net 1995 payment rate update measured from claims (3.8 percent) was significantly smaller than the 6 percent estimate used in last year's projections. The difference is accounted for by factors that affect payment rates but are not entered into the published conversion factor update.[11]

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[9] Arriving at a current (1996) fee estimate requires projecting from the most recent available data. For private payers, that consists of 1994 claims and market share information. For Medicare, that consists of mid-year 1995 claims and published 1996 fee updates.

[10] Each percentage point reduction in the assumed level of HMO fees changes the Medicare-to-private fee gap by roughly 0.15 percentage points. Thus, assuming that HMOs paid at the Medicare rates (rather than at 120 percent of Medicare) would narrow the gap by roughly 3 percentage points.

[11] For example, the budget-neutral introduction of new Current Procedural Terminology (CPT) codes results in across-the-board reductions in payment rates. This issue is discussed in more detail in Chapter 9.

The published 1996 Medicare payment rate update of 0.8 percent was reduced to 0 percent for this calculation based on similar considerations.[12]

Results. The revised data show no qualitative change from the picture presented last year. The ratio of Medicare to private payment rates continues to rise from its low in 1992, although slowly. Currently, the gap between Medicare and private rates is estimated to be at the same level as it was in 1989.

Medicare is estimated to have paid 70 percent of private rates in 1995 (Table 12-3). This is 2 percentage points higher than the 1995 projection of 68 percent reported last year. Newer data and assumptions of lower HMO payment rates resulted in a revision of last year's projection for 1995.

The revised ratio of 70 percent is projected to increase to 71 percent in 1996. This increase occurs despite no increase in Medicare payment rates, because private payment rates are projected to fall somewhat. This is due both to an assumed 1 percent reduction in private indemnity/PPO payment rates and an assumed 5 percentage point increase in HMOs' share of private physician revenues.

Table 12-3. Relationship Between Medicare and Private Payers' Rates, 1989-1995

Fee Index	1989	1990	1991	1992	1993	1994	1995	1996
Medicare Fee Index (1989 = 100)	100	102	98	95	96	99	103	103[b]
Private Fee Index (Medicare 1989 = 100)	141	146	150	154	155	150[a]	147[b]	145[b]
Ratio of Medicare to Private Fee Index	0.71	0.70	0.65	0.61	0.62	0.66	0.70[b]	0.71[b]

SOURCE: Physician Payment Review Commission analysis of Medicare and private payer claims data.

[a] Discontinuity in series due to a change in assumptions regarding HMO payment rates.

[b] Projected.

Discussion and Future Directions for Monitoring Private Payment Rates. The Commission's data provide a reasonably credible estimate of national average private payer physician payment rates. The Commission's indemnity/PPO database contains information on roughly 15 million privately insured lives, with four independent sources of claims to provide validity checks. Significant effort is expended to calculate a true price index from the included claims.[13] Augmented by an estimate of HMO payment rates, the data exhibit the conventional ranking of private payers (commercial insurers pay highest, HMOs lowest) and capture the recent dramatic slowdown in private payment rate inflation that coincides with the shift of private enrollment out of indemnity plans.

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[12] While the actual change in Medicare payment rates for 1996 may even be less than zero, a slight decrease would have a minimal effect on the gap estimate.

[13] This involves identifying and removing claims for partial payment (e.g., Medigap) and minor services (e.g., surgical followup billed separately), as well as calculating a fee index so that differences in payers' mix of services has only a second-order effect on the estimated fee level.

While the Commission has focused on the national average—weighting payers, regions, and services in proportion to overall private market share—other benchmarks might be useful. These include looking at selected services, selected markets, or selected payers. Because payment rate levels vary enormously, these could give a quite different view of the Medicare-to-private payment rate gap.

First, the gap between Medicare and private rates is much smaller for office visits and other primary care services than it is for tests and procedures (PPRC 1995a). This is due to the Medicare Fee Schedule's shifting of payment toward primary care and away from other services. Because most data show that primary care physicians are in relatively short supply but specialists are in excess supply, this suggests that access monitoring might concentrate on payment rates for office visits, under the assumption that this is the area where Medicare must remain most competitive with private payers.

Second, the gap between Medicare and private payment rates varies significantly across market areas. Highly competitive markets with significant physician surpluses, such as southern California or south Florida, show much lower average private payment rates than other parts of the country. Currently, there is no provision in law that allows Medicare to modify its payment rates in response to such local market conditions, either lowering them to take advantage of excess physician supply or raising them in areas with evident access problems. Objectively documenting such areas might be a first step toward accommodating local market conditions within Medicare's rate-setting structure.

Third, the gap between Medicare and private rates varies significantly by payer. Blue Cross Blue Shield plans, for example, have long maintained a discount relative to commercial insurers, while PPOs and HMOs typically pay less than indemnity insurers. Because enrollment is growing in plans of the more heavily discounted payers, physicians' economic opportunities may be measured best by tracking payments among the discounted payers such as HMOs, rather than the average of all payers.

Finally, increased enrollment in HMOs raises serious long-term questions about the availability and interpretation of payment rate data. The Commission's current HMO payment rate estimate is subject to considerable uncertainty, and that becomes more important as HMO market share increases.

Because HMOs do not routinely generate third-party claims, there is relatively little commercially available information on their payment rates. Only one corporation appears to produce a nationwide set of HMO and other managed-care plan payment rate data, based on its own intensive surveys of managed-care plans. As with any payment rate schedule data, it is difficult to translate this information into an estimate of average HMO payment rates because the payment rate schedule carries no information about the quantity of care delivered. Fee schedule data can demonstrate the lowest and highest payment rates paid, but do not show what portion of services were paid at each level.

More generally, payment rates from HMOs may not be directly comparable to payment rates from indemnity plans such as Medicare. For Medicare, the payment rate represents nearly all the financial interaction between payer and physician. For HMOs, however, the typical physician contract specifies much more than just the payment rate level. Total remuneration may be based partly on the payment rate, but also in part on performance-related bonuses and withholds, on compliance with other aspects of

management of care, and on patient satisfaction. All of these reflect the fundamental difference between a fee-for-service payer such as Medicare and capitated HMOs.

As HMOs and other capitated plans grow both for the privately insured and for Medicare, it may be necessary to move beyond comparing payment rates toward other sources of information. Medicare rates could be compared to some measure of physicians' costs, or to an estimate of physicians' additional practice revenue for each additional hour worked. Alternatively, Medicare rates could be compared to private premiums.[14] This is a much more complex task than examining payment rates, however, and would require adjusting data both for the risk mix of enrollees and for comparability of the benefit packages underlying the premiums.

Hotspots of Poor Access

While the average Medicare beneficiary has good access to care, there have been persistent accounts of areas where the percentage of beneficiaries having difficulty finding physicians is unusually high. Discussions with medical societies, beneficiary advocacy groups, congressional offices, and others identified about two dozen communities where beneficiaries were thought to have considerable difficulty finding a physician.

To take a more systematic look at these possible hotspots of poor access, the Commission entered into a joint research project with the National Committee to Preserve Social Security and Medicare. The National Committee is a grassroots education and advocacy organization representing about 6 million members and supporters, most of whom receive Social Security or Medicare benefits.[15]

Sixteen potential hotspots of poor access were chosen based on prior surveys by the National Committee and an ad hoc list of areas maintained by the Commission. The National Committee mailed a survey on access to care (along with cover letter and postage-paid return envelope) to more than 53,000 older people (Medicare and privately insured) living in these 16 areas and in a randomly chosen national control group. More than 12,000 surveys were returned for an overall response rate of 23 percent.[16]

Nationally, 7 percent of Medicare and 7 percent of older privately insured persons reported difficulty finding a physician during the year, and roughly 1 percent had an active problem finding a physician at the time of the survey (Table 12-4). Some areas, however, had higher rates of reported problems. Northwestern Arizona had a reported problem rate of almost three times the national average, while the Boise/Twin Falls area of Idaho had a reported problem rate of about twice the national average. In these areas, both Medicare and non-Medicare individuals had problems finding a physician. Altogether, 7 of the 16 potential hotspot areas showed some statistically significant indication of above-average access problems.

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[14] One effort to get nationally representative premium data is the National Employer Health Insurance Survey, which surveyed more than 36,000 business establishments in 1994 to obtain information on benefits and premiums. This undertaking is a joint effort by Medicare, the National Center for Health Statistics, and the Agency for Health Care Policy and Research.

[15] William J. Lessard, Jr., directed the National Committee's portion of this project.

[16] This response rate may be typical of surveys without nonrespondent followup.

Table 12-4. Persons Reporting Problems Finding a Physician in Potential Hotspot Areas, by Type of Insurance (percentage)

Area Name	Type of Insurance	Percent with Problem	Percent with Unresolved Problem
National Control	Medicare	7.1%	1.1%
	Private	7.4	1.0
Arizona (Northwest)	Medicare	21.5*	3.9
	Private	18.4*	0.0
Idaho (Boise/Twin Falls)	Medicare	13.5*	1.3
	Private	11.5	1.9
Texas (Forth Worth)	Medicare	13.5*	2.3
	Private	6.7	2.5
Louisiana (Southwest)	Medicare	12.4*	0.0
	Private	6.1	1.0
Texas (Amarillo/Panhandle)	Medicare	10.4*	0.7
	Private	18.3*	5.0
Washington (South Central)	Medicare	10.2*	1.6
	Private	14.5*	0.0
Alabama (Northeast)	Medicare	9.4*	0.8
	Private	3.7	0.0

SOURCE: Physician Payment Review Commission analysis of National Committee 1995 Access Survey.

* Statistically significant at the 5 percent level.

NOTE: No significant differences were found in California (Northeast), Connecticut (Eastern), Florida (Orlando), Illinois (East St. Louis), Michigan (Saginaw), North Carolina (Asheville), Nevada (Reno/Carson City), New York (Southwest), Ohio (Toledo).

This pilot survey demonstrates that hotspots of poor access to care are a real phenomenon, but suggests that problems in many areas are marketwide and not specific to the Medicare population. Nationally, the survey agrees with prior Commission research showing that physicians are as likely to take new Medicare patients as they are to take new privately insured ones.

It is difficult to identify what level of reported access problems should warrant action by the Medicare program. In the worst area, 4 percent of beneficiaries reported an active problem finding a physician at the time of the survey. Such areas should be studied more closely to see if problems persist and to better understand the nature of the reported problems.

MONITORING BENEFICIARIES' FINANCIAL LIABILITY

As an extension to its access monitoring efforts, the Commission also examines aspects of beneficiaries' financial liability that are affected by physician payment policies. The fee-for-service Medicare program

contains a number of policies intended to protect beneficiaries from excessive out-of-pocket expenses. Providers are allowed to bill on assignment, whereby they accept the Medicare payment amount as full compensation and receive most of the payment directly from Medicare. The Participating Physician and Supplier (PAR) program provides incentives for physicians to accept all of their claims in this assigned manner. Further, for claims that are not assigned, OBRA89 specifies percentage limits on the amount that physicians can bill beneficiaries above Medicare's payment amount. These policies leave Medicare beneficiaries responsible for a $100 deductible, coinsurance of 20 percent of the Medicare Fee Schedule payment amount, and additional charges (balance bills) of at most 15 percent of the Medicare payment for physicians' services provided on a fee-for-service basis.[17]

Recent data indicate these policies to limit beneficiary financial liability have been successful. For example, the proportion of Medicare claims paid on assignment is high and climbing, from about 70 percent in 1986 to 95 percent in 1995. This higher assignment rate is mirrored by increased rates of participation. In 1995, 72 percent of providers billing Medicare took part in the PAR program. These participating providers accounted for about 90 percent of Medicare charges for physicians' services that year.

For the remaining charges that are not billed on assignment, beneficiaries' cost sharing in most cases has been effectively contained by Medicare's limiting charges. Preliminary analysis of unassigned claims with balance bills submitted during 1995 shows that on average, balance bills were 15 percent of the fee schedule payment. This rate is lower than the 1994 rate of 17 percent and the 1993 rate of 23 percent. Although the 1995 average of 15 percent may indicate that some bills remain above the limiting charge, Commission analyses have found that most charges that exceed the limit do so by relatively small amounts (PPRC 1995b). The increased compliance with the limiting charge is likely the result of HCFA's stepped-up efforts to inform both providers and beneficiaries of any overcharges. Legislation enacted in 1994 clarified HCFA's authority to enforce the charge limits and requires providers to refund any overcharges.

FUTURE WORK ON MONITORING ACCESS AND FINANCIAL LIABILITY

The Commission will issue detailed reports on beneficiary access and financial liability in mid-1996. These reports will present more in-depth analyses of the issues addressed in this chapter.

The access report will include further analyses of CBS and Medicare claims data. A special emphasis of these analyses will be access to care for vulnerable groups of beneficiaries—the oldest-old (over 85), African Americans, and beneficiaries living in urban and rural poverty areas, among others.

The Commission's report on beneficiary financial liability will provide more detailed analyses of charges corresponding to specific types of services, specialties of physicians, and geographic and demographic attributes of both providers and beneficiaries. This year, in response to interest in expanding the number

[17] Most beneficiaries (about 85 percent) are covered by some form of supplemental insurance policies that provide reimbursement for all or most of these cost-sharing expenses.

and types of private insurance options available to beneficiaries, the Commission has considered how beneficiaries' financial liability might be affected by such changes (see Chapters 2 and 3). In its forthcoming report, the Commission will pay attention to methods to expand its financial liability monitoring activities to accommodate beneficiaries enrolled in risk-contracting plans.

Additional Access Monitoring Work

In addition to work for the upcoming access report, the Commission plans other access monitoring work that builds in part on previous efforts. Its plans also reflect the need for access monitoring to adapt to Medicare program changes. The planned work will address both the Medicare fee-for-service and managed-care programs.

Medicare Fee for Service. Thus far, monitoring access in Medicare fee for service has focused on effects of introduction of the Medicare Fee Schedule in 1992. Through a five-year transition, changes in service use before and after the fee schedule's introduction have been studied along with changes in access measures from the CBS. Within this framework, vulnerable groups, such as African Americans and those 85 and older, have been compared with others on the assumption that they may be most likely to encounter any access problems that develop. Monitoring has shown that access remains good for most beneficiaries, but that vulnerable groups appear to face barriers that predate the fee schedule.

The consistency of these findings, based on data from the first several years of fee schedule implementation, suggests that access monitoring can be refocused somewhat. The focus can shift from the initial years of the fee schedule to more recent policy changes affecting physician payment. Furthermore, the persistent access problems of vulnerable populations suggest that more effort should be devoted to finding solutions to these problems, and less to measuring their magnitude.

In general, the refocusing of access monitoring will be modest. Aside from shifting the 1991 baseline of the analyses to later years, the Commission will continue to use the same monitoring tools it has in the past. These tools are flexible enough to detect changes in access that could accompany future changes in physician payment rates. Such changes could be brought about by the Volume Performance Standard system (see Chapter 10). Conversion to resource-based practice expense relative values is another possible source of payment rate changes (see Chapter 9).

Other shifts in the Commission's access work will be more noticeable. Work on solutions for the access problems of vulnerable populations, for example, will be one new thrust.

Plans for new work on monitoring access under Medicare fee for service are outlined below. They are organized under four topics: access of vulnerable populations, hotspots of poor access, risk adjustment of access measures, and the proportion of physicians providing services to beneficiaries.

Access of Vulnerable Populations. The Commission has found that some vulnerable groups face access barriers. For example, African Americans and those living in urban poverty areas have higher mortality rates, use fewer primary care services, and make greater use of emergency rooms than other

beneficiaries. These problems are not unique to the Medicare program but are characteristic of the U.S. health care system in general.

To move debate toward solutions for these problems, further work will explore the possible reasons for this poorer access, including the role played by provider supply and whether greater use of emergency rooms is associated with a higher incidence of emergent conditions like hip fracture. Some research has already been done on such issues. A summary of these studies and additional work by Commission staff is planned.

The Commission will also look for examples of strategies that have been found to be successful in removing access barriers for vulnerable populations. It already has done some work in this area by sponsoring a research project on models of care for inner-city populations (Zuvekas et al. 1994). Other research and demonstrations sponsored by HCFA should also be useful in identifying potential ways to improve access for these groups.

Hotspots of Poor Access. As discussed earlier in this report, some geographic areas may be hotspots of access problems. Continued identification of such areas could be an important part of further access monitoring, for these areas could signal emerging access problems. The identification of hotspots could trigger design of payment policies that could address local access problems. Further investigation would be necessary, however, to see if there are local conditions, such as a temporary provider supply problem, not unique to Medicare.

The hotspots survey conducted by the National Committee to Preserve Social Security and Medicare shows the limits of using surveys to identify hotspots. One alternative is to use claims data for a hotspots analysis. Such an analysis could use a set of clinical indicators of access developed by RAND under contract to the Commission (PPRC 1995c). These 47 indicators identify services that represent necessary care in particular circumstances. Claims data are used to determine the extent to which Medicare beneficiaries receive those services. RAND is currently attempting to summarize the indicators with a single index. Such an index may be useful in a relatively large-scale scan of the nation for hotspots of access problems.

Risk Adjustment. Growth in Medicare HMO enrollment could complicate monitoring access in the Medicare fee-for-service program. The presence of coverage options means that risk selection may occur with more or less healthy beneficiaries remaining in fee for service. If there is risk selection unfavorable to fee for service, use of services in Medicare fee for service, measured on a per beneficiary basis, could increase. This increase may obscure any reductions in service use and access that these beneficiaries otherwise experience. Conversely, if there is risk selection that is favorable to fee for service, use of services in fee for service could fall, suggesting a reduction in access even if none had occurred.

If there is a possibility of risk selection, consideration must be given to risk adjustment of measures of service use. As discussed in Chapter 15, available risk adjustment techniques have limitations. Nonetheless, risk adjustment can remove at least some of the effects of risk selection from measures of service use. The measures would then be better measures of access.

Proportion of Physicians Serving Beneficiaries. For the past two years, the Commission has been analyzing Medicare claims data from a sample of physicians to measure physician willingness to provide services to beneficiaries. These analyses have been limited since they rely solely on Medicare data and only show the extent to which the number of physicians providing services to beneficiaries is keeping pace with growth in the beneficiary population. No comparisons have been possible between the number of physicians serving beneficiaries and the total supply of physicians. With data on overall physician supply, the Commission could measure the proportion of physicians providing services to beneficiaries. Such measurement could provide a more complete perspective on physician willingness to treat beneficiaries.

During the coming year, the Commission will explore the availability of data on total physician supply from the American Medical Association. If the data can be matched with Medicare claims files, comparison of total physician counts with counts of physicians providing services to Medicare beneficiaries should be possible.

Monitoring Access in Medicare Managed Care

In last year's report on beneficiaries' access to care, the Commission introduced its plans to develop a framework for monitoring the access of beneficiaries enrolled in Medicare managed-care plans (PPRC 1995c). This work was motivated by recent rapid growth and expected future growth in managed-care enrollment, and recognition that an access monitoring approach should take into account the differences in alternative service delivery models. The report also described current and potential sources of data for an ongoing monitoring system, and considered the need to identify subpopulations of Medicare beneficiaries who might be vulnerable to access problems in a managed-care delivery system.

Over the past year, the Commission's work in this area has been focused primarily on two tasks: development of a survey on access to care for Medicare managed-care plan enrollees and disenrollees, and work in identifying groups of beneficiaries vulnerable to access problems in Medicare managed care. These projects are described below. Plans for monitoring access under a restructured Medicare program are also discussed.

Medicare Managed-Care Access Survey. Unlike the relatively rich sources of data for monitoring access in fee-for-service Medicare—claims data and data from the annual Medicare Current Beneficiary Survey—data available for monitoring access in the Medicare managed-care program are much more limited. The Commission is sponsoring a Medicare managed-care access survey to help overcome the limitations of existing data for monitoring access to care in the Medicare managed-care program. The survey is expected to provide baseline data on access to care, as well as experience on sampling design and access measurement issues that can inform efforts to collect this type of information on an ongoing basis.

The Commission has contracted with Mathematica Policy Research to develop and field a survey of Medicare risk-contract plan enrollees and disenrollees on their access to care. To date, a number of key tasks have been completed. Instrument development and sampling design decisions have been made based on input from several sources. First, relevant studies and the literature on managed-care access were

reviewed to identify access issues and measures. Focus groups of Medicare beneficiaries were also held to gain insight into the beneficiary perspective on these issues and to explore newly identified issues in greater depth. These issues and measures were further developed and refined by a panel with expertise in access to care, survey measurement of access, managed care, and Medicare beneficiary concerns. The survey will be fielded this summer and results analyzed in the fall of 1996.

Vulnerable Populations. The Commission has also begun work to identify and explore whether certain populations may be at risk for access problems in Medicare managed care. This effort grew out of the Commission's work on identification of groups particularly vulnerable to access problems under fee-for-service Medicare.

Some of the same groups that the Commission has identified as vulnerable in fee-for-service Medicare may also be at risk for access problems in Medicare managed-care. These groups include African American beneficiaries and those who live in Health Professional Shortage Areas or urban or rural poverty areas. Beneficiaries in these groups could continue to be at risk to the extent that the underlying reasons for their vulnerability were unaffected by the managed-care delivery system; for example, where access problems stem from a lack of transportation.

In addition to the groups already identified, the Commission has defined two general categories of beneficiaries who may be at risk for access problems under managed-care delivery systems. A first group includes those who need resource-intensive care on an ongoing basis. A second group includes those who may have difficulty navigating a managed-care system, whether because of medical or mental health, economic, sociological, or other factors. Because beneficiaries in these groups are difficult to identify a priori, the Commission's Medicare managed-care access study will analyze the access to care of disabled beneficiaries and those over 85 as proxy categories for certain types of beneficiaries in these vulnerable groups.

The Commission also recognizes that managed-care delivery systems could improve access for some beneficiaries in vulnerable groups. The potential for improving access, however, will depend on the strategies that managed-care plans adopt to care for beneficiaries in general and for those at risk for access problems. Therefore, the Commission plans to explore innovative approaches managed-care plans might use to identify and serve vulnerable beneficiaries. As a first step in this effort, the Commission convened a panel of experts in the delivery of managed care to vulnerable groups. The panel's input is being used to develop the framework for the Commission's future work in this area.

Monitoring Access to Care under a Restructured Medicare Program. The Commission's efforts to adapt its access monitoring approach to increased beneficiary enrollment in HMOs has coincided with considerable interest in expanding beneficiary coverage options among policymakers. Proposed changes in the financing and delivery of medical services under the Medicare program would need to be considered in adapting the Commission's monitoring approach to ensure the continued ability to document any resulting changes in access.

Medicare restructuring proposals developed by the Congress and by the Administration would open up the Medicare program to a greater variety of health plans. The congressional conference agreement (H.R.

2491), for example, would expand options under Medicare to include provider-sponsored organizations, preferred provider organizations, unrestricted fee-for-service health plans, and high-deductible plans combined with medical savings accounts. These options could range widely in terms of benefits provided (beyond the basic Medicare benefits package), cost-sharing arrangements, lock-in requirements, provider incentives, and care-management capacities. Wide variation in plan features would be expected both across plan types and within categories of plans.

Over the coming year, the Commission will undertake work to address key issues that could arise in monitoring access to care under a restructured Medicare program. These include issues surrounding development of an access monitoring framework that could accommodate a continuum of delivery arrangements and identification of data, measures, and vulnerable groups for targeted monitoring efforts. The Commission will explore the potential of data that could be generated at the health plan level, including encounter data, to serve in a monitoring capacity. It will consider both measures that are comparable across plan options and fee for service and measures that are comparable across different types of plans. Additional work in this area will be to investigate health plans' best practices for ensuring access to care for Medicare beneficiaries in general and for vulnerable groups in particular.

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The Failsafe Budget Mechanism

Expectations of a high rate of growth in Medicare expenditures have raised concerns that Medicare spending will hamper efforts to reduce the federal deficit. To curb program spending, the Congress passed a conference agreement (H.R. 2491) in November 1995 that would restructure the Medicare program. Among the proposed changes is the establishment of a spending ceiling for the entire Medicare program called the failsafe budget mechanism. While this mechanism would safeguard against unrestricted growth in program spending, it is specifically crafted to meet deficit reduction objectives—scored savings of $270 billion by the year 2002, based on economic assumptions of the Congressional Budget Office (CBO) and its analyses of the conference agreement.

Although many agree conceptually with the intent of a policy to slow Medicare spending growth, there is no consensus on the solution. The possible options for reaching this goal range broadly from refining current payment mechanisms to developing a second tier of spending constraints, such as expenditure limits or expenditure targets. Each option varies not only in its effectiveness, but also in its effects on the various individuals and institutions that furnish care to Medicare beneficiaries.

The failsafe budget mechanism is an expenditure limit system that would establish a ceiling on total spending, reducing fee-for-service payments when spending is expected to exceed that ceiling. The mechanism would operate by first determining an allowance for fee-for-service Medicare calculated by subtracting projected spending for private risk-based plans from the overall spending limits for the entire Medicare program. The mechanism would then allocate shares of fee-for-service spending across service sectors (such as inpatient hospital, home health, and physicians' services). If projections of spending showed that the

This chapter includes:

- *Policy considerations for constraining Medicare spending*
- *Description of the failsafe budget mechanism*
- *Limitations of the failsafe budget mechanism*

fee-for-service limit would be exceeded in that year, fee-for-service payments would be prospectively reduced in service sectors that were expected to cause the overspending.

The failsafe budget mechanism, as currently proposed, may not operate as intended because of several methodological limitations. First, it would only lower payment levels, but have no provision for increasing them. Because payments would be dropped permanently, continuing to apply in years with no projected excess spending, the mechanism would take larger reductions than needed to meet budget goals. The mechanism could be modified, however, so that reductions were in effect for one year only and were then returned to the level they would have achieved had the failsafe budget mechanism not been triggered. With this change, reductions to fee-for-service payments would more closely reflect intended budget goals.

In addition, payment reductions under the failsafe budget mechanism might also reflect fluctuations in annual spending and errors in projected spending. While the mechanism would correct for previous overspending resulting from projections that were too low, it would not adjust for projections of spending that were too high. The failsafe budget mechanism could be improved to better limit the effects of annual variation by revising the methodology so that spending shortfalls in one year offset spending excesses in others. This mechanism could also adjust for all errors in projected spending.

Recommendation

If the failsafe budget mechanism is adopted, it should be modified in three ways. Any payment reductions should apply for one year only, and then payment levels should be returned to the level they would have achieved had the failsafe budget mechanism not been triggered. The mechanism should also be based on comparisons of total actual spending and total allowed spending accrued since a base year. In addition, it should correct annually for any projection errors regardless of whether these errors were too high or too low.

This chapter describes the failsafe budget mechanism in the context of a range of policy options for constraining Medicare spending, highlighting the inherent difficulties and trade-offs required to develop any budget mechanism. It also discusses the challenges of assessing the potential impact of any such policy. The chapter begins by describing two general strategies, expenditure limits and expenditure targets. It then addresses the complications that arise when assigning spending allocations across service sectors, problems in addressing fluctuations in annual expenditure growth, and the need to maintain consistency among the wide range of payment mechanisms used by the Medicare program. The chapter concludes with a more detailed look at the failsafe budget mechanism, using simulations to explain technical limitations that may keep it from working as intended.

POLICY ISSUES FOR CONSTRAINING FEE-FOR-SERVICE SPENDING

Constraining fee-for-service spending is challenging because of the difficulty in controlling the two forces that drive higher spending: rising prices and increases in the number and mix of services per beneficiary (also called volume and intensity growth). While the Medicare program determines how

much it will pay for a given service, it does not control the number and type of services provided. As a result, expected savings from payment reductions can be offset by increases in volume and intensity growth.

Two strategies for constraining spending are *expenditure targets* and *expenditure limits*. An expenditure target system sets an allowed amount of spending, and then adjusts payments up or down so that actual spending matches the allowed allocation. This ensures an average rate of growth over time. The existing Volume Performance Standard (VPS) and the proposed Sustainable Growth Rate systems for setting payments for physicians' services are examples of expenditure target policies.[1] In these systems, payment levels are linked to growth in the volume and intensity of services. If growth in volume and intensity is too high, payment levels are lowered to reduce total spending to target levels. If the growth rate is lower than expected, then payment levels are increased. Total Medicare spending for physicians in fee for service is thereby kept fairly predictable because, regardless of the number and intensity of services provided, Medicare program spending is held to the level of the established targets.

Alternatively, an expenditure limit system sets a ceiling for spending and adjusts payments downward when spending exceeds this limit. If spending is below the limit, the payment is not adjusted and the shortfall is garnered as additional savings to the Medicare program.

The following example illustrates how the expenditure target and limit systems operate. The example uses actual growth in Medicare spending from 1983 to 1993 and shows how 5 percent expenditure target and limit systems would have worked had they been in effect during that period (Table 13-1). The expenditure target system would adjust payments each year so that the annual expenditure growth rate was held to 5 percent. The expenditure limit system, by contrast, would have reduced payments levels in 1983 and 1984 to hold expenditure growth to 5 percent, but would have made no changes to payment levels in 1985 when the spending growth rate was only 4.3 percent. Given the same allowed rates of growth, expenditure limits hold spending to the same or lower levels of spending relative to expenditure targets.

Several difficulties arise when designing systems of either expenditure targets or expenditure limits to constrain spending. First, decisions must be made as to how to allocate total Medicare fee-for-service spending across service sectors. This has important implications for the efficiency of health care delivery and the substitution of services across the sectors. Another problem is the fluctuation in year-to-year spending. Annual variation in overall spending can be substantial, and this variation can be magnified within each of the sectors. Finally, the system of expenditure targets or limits must be compatible with the payment mechanisms used to establish payment levels and annual updates within each sector. In the following sections, potential approaches for addressing issues of allocating spending across sectors, volatility, and compatibility with payment mechanisms are presented for both expenditure targets and expenditure limits. Finally, some additional considerations for designing systems to limit spending growth are discussed.

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[1] The Sustainable Growth Rate system, proposed in the conference agreement, would replace the Volume Performance Standard system.

Table 13-1. Per Capita Spending and Growth Rates Using 5 Percent Expenditure Targets and Expenditure Limits, 1983-1993

Year	Actual Expenditures		Expenditure Target of 5 Percent		Expenditure Limit of 5 Percent	
	Per Capita	Annual Growth	Per Capita	Annual Growth	Per Capita	Annual Growth
1983	$1,851	8.1%	$1,851	5.0%	$1,851	5.0%
1984	2,001	11.8	1,944	5.0	1,944	5.0
1985	2,237	4.3	2,041	5.0	2,041	4.3
1986	2,332	5.5	2,143	5.0	2,128	5.0
1987	2,461	5.4	2,250	5.0	2,235	5.0
1988	2,594	8.0	2,363	5.0	2,346	5.0
1989	2,802	11.8	2,481	5.0	2,464	5.0
1990	3,134	4.3	2,605	5.0	2,587	4.3
1991	3,269	11.0	2,735	5.0	2,698	5.0
1992	3,629	9.8	2,872	5.0	2,833	5.0
1993	3,986	8.6	3,016	5.0	2,975	5.0

SOURCE: Physician Payment Review Commission analysis of actual expenditures and enrollment rates from the Health Care Financing Administration.

Allocation of Spending across Sectors

A policy to constrain Medicare spending must first determine how to allocate any spending reductions across categories of services. This requires defining suitable categories and establishing an initial allocation of spending for each category. In addition, the policy must provide a method for changing the allocations over time as appropriate.

The choice of categories and the method of allocating across these categories have important implications for how the policy will affect health care delivery. Changes in payment levels across service sectors can change incentives related to where and how care is provided. For example, a policy that would have locked in shares of spending by service sector in the 1980s could have hindered innovations that moved many services from hospital inpatient to ambulatory care settings.

Categories of Services. A natural categorization of service sectors follows Medicare's policies for paying providers and institutions. Part A services are divided into four sectors: inpatient hospital, skilled nursing facility, home health, and hospice, while Part B services include physicians' services, outpatient hospital services, and other medical services, like durable medical equipment.

When the Commission addressed the issue of expenditure limits in 1993, it concluded that relatively few categories should be established. It recommended designing the categories to give appropriate incentives to groups of providers and confining most substitution of services within, rather than across, the categories. The Commission also recommended establishing a process to track substitutions across categories.[2]

[2] The Commission's analysis, presented in *Expenditure Limits: Design and Implementation Issues,* discusses allocations of spending across service sectors, setting expenditure limits by states, and data needs for expenditure limits and rate setting (PPRC 1993b).

The failsafe budget mechanism allocates spending across nine sectors: inpatient hospital services, home health services, extended care services (including skilled nursing facilities), hospice care, physicians' services, outpatient hospital services, durable medical equipment and supplies, diagnostic tests, and other items and services. This generally follows the categories of payment already established within the Medicare program.

Allocation of Spending. One strategy for allocating spending across service sectors would be to establish baseline levels of spending using historical trends. The amount of allowed spending for a given year could then be proportionally allocated across the sectors using these baseline levels. Currently, the inpatient hospital sector accounts for the largest share of Medicare spending (Table 13-2). In 1993, inpatient hospital services represented 52 percent of total Medicare outlays, while physicians' services represented 24 percent.

Determining how these allocations should change over time is more difficult. It would require forecasting appropriate and efficient substitution of services within each service sector, which in turn would require predicting new trends in medical innovation and technology.

One approach is to use historical trends to predict future changes. From 1983 to 1993, spending for inpatient hospital services declined from 65 percent to 52 percent of total Medicare spending (Table 13-2). From this trend, one might expect a continued decline. On the other hand, the share of spending for physicians' services has remained relatively stable, at 23 percent in 1983, rising to 28 percent in 1988 and 1989, and then falling to 24 percent in 1993. The 11-year pattern suggests that the share of physicians' spending might remain constant, while the most recent 5-year pattern suggests a slow decline.

Table 13-2. Share of Total Medicare Outlays, by Service Sector, 1983-1993 (percentage)

Year	Inpatient Hospital	Physicians	Outpatient Hospital	Home Health	Skilled Nursing Facility	Hospice	Other	Total
1983	65%	23%	6%	3%	1%	0%	2%	100%
1984	64	24	6	3	1	0	2	100
1985	65	23	6	3	1	0	2	100
1986	63	25	7	3	1	0	2	100
1987	59	27	7	2	1	0	3	100
1988	57	28	8	2	1	0	3	100
1989	56	28	8	2	2	0	4	100
1990	55	27	8	3	3	0	4	100
1991	53	27	8	4	2	0	5	100
1992	54	25	8	5	3	1	4	100
1993	52	24	8	7	4	1	5	100

SOURCE: Physician Payment Review Commission analysis of actual expenditures and enrollment rates from the Health Care Financing Administration.

NOTE: Percentages may not sum to 100 percent due to rounding.

Using historical trends to project future spending, however, can be problematic. Because of year-to-year variation, it is hard to determine if a few years of decline in expenditure growth signals the beginning of a continuing downward trend, or if expenditure growth will return to higher historical levels. As a result, some projections may assume that downward trends will be reversed and hence project a return to historical averages. Other estimates may project a continuing downward trend.

The failsafe budget mechanism uses 1995 baseline spending levels and projections of expenditure growth by service sector from CBO's March 1995 baseline to set relative spending levels for 1996 to 2002. By 2002, the share of spending for inpatient hospital care would be expected to fall from about 45 percent in 1996 to roughly 38 percent in 2002. The share for outpatient hospital care would rise from about 6 percent to about 9 percent. The shares for other sectors would show modest increases, offsetting the reduced share of inpatient hospital care. Under this mechanism, the shares established for 2002 would apply for each year thereafter.

The importance of baseline allocations and how changing them might affect payment levels depends partly on the stringency of the spending limits. If these limits are set so low that the failsafe budget mechanism is likely to be triggered, inaccuracies in the baseline allocations and forecasts of spending shares would have a greater effect on payment levels in sectors with excess spending.

Managing Year-to-Year Volatility

Because annual expenditure growth rates for Medicare spending are unpredictable and highly variable, it is difficult to set policies to constrain spending. From 1983 to 1993, for example, annual growth rates ranged from a low of 4.3 percent to a high of 11.8 percent (Table 13-1). From 1989 to 1991, growth rates fell from 11.8 percent to 4.3 percent, then rose to 11.0 percent. Such high variation makes it hard to design a policy that sets predictable rates of spending without imposing payment levels that fluctuate widely from year to year.

The fluctuation in annual expenditure growth rates is magnified within each of the service sectors. Inpatient hospital services—the largest sector—had annual growth rates ranging from 2 percent to 15 percent (Table 13-3). Year-to-year fluctuations were even greater in the smaller sectors such as skilled nursing facilities, home health, and hospice. How much of these fluctuations was caused by Medicare payment policy and how much by changes in utilization patterns is difficult to determine.

The challenge is to develop policies that achieve the desired rate of growth without producing large annual fluctuations in payment levels. Under expenditure targets and limits, the rate of Medicare spending would be more predictable, since these systems would smooth growth rates by changing payment levels. The drawback is that the annual fluctuation in expenditure growth rates would be shifted to the annual adjustments in payment levels, making payment levels unpredictable for providers.

The Sustainable Growth Rate system, an expenditure target system proposed for physicians' services, would use a different strategy than the failsafe budget mechanism for managing annual fluctuation. Their differences reflect, in part, a trade-off between reducing annual variation in each sector's expenditure

Table 13-3. Annual Growth in Medicare Expenditures, by Service Sector, 1984-1993 (percentage)

Year	Inpatient Hospital	Physicians	Outpatient Hospital	Home Health	Skilled Nursing Facility	Hospice	Other
1984	9%	13%	6%	18%	2%	0%	9%
1985	15	11	11	11	0	750	23
1986	2	14	26	2	5	100	1
1987	2	18	17	-6	9	53	32
1988	4	11	12	11	18	32	34
1989	7	8	13	12	214	54	13
1990	13	11	14	49	22	51	24
1991	2	7	10	49	-12	51	24
1992	14	4	16	40	45	69	9
1993	8	5	12	36	38	19	19

SOURCE: Physician Payment Review Commission analysis of actual expenditures and enrollment rates from the Health Care Financing Administration.

growth and in reducing variation in each sector's share of total spending. The failsafe budget mechanism would address such variation by lowering payments in sectors with excess spending if total spending across all sectors exceeded the fee-for-service limit. This would allow spending surpluses in some sectors to offset excess spending in others. If no excess spending occurred, the surplus would accrue to the Medicare program as savings.

The strategy adopted by the failsafe budget mechanism would be more effective if shares of spending across the sectors varied from year to year. From 1983 to 1993, however, each sector's share remained relatively stable despite substantial swings in annual growth rates (Tables 13-2, 13-3). Further, because spending for inpatient hospital care represents such a large share of total fee-for-service Medicare spending, the impact of the failsafe budget mechanism would depend largely on this sector. While a surplus in the inpatient hospital sector might offset excess spending in other sectors, it is unlikely that the converse would be true.

Under the strategy of the Sustainable Growth Rate system, fluctuations in spending would be addressed by limiting the size of annual increases or reductions in payment levels. Excess or surplus spending that fell outside the limits would be accounted for in subsequent years. With this approach, each sector would be accountable for staying within its own spending limits. As a result, establishing the appropriate allocations for each sector would be especially important. A sector with a payment mechanism that constrains spending growth less effectively would be most apt to trigger reductions.

Compatibility with Existing Payment Mechanisms

Owing to the complexity and variety of the payment mechanisms now used in the Medicare program, it is difficult to ensure that any particular expenditure target or limit system would be compatible with all of the payment mechanisms. Existing payment mechanisms might conflict with systems of expenditure limits or

targets in various ways. If, for example, a sector's payment mechanism provided a full allowance for inflation, but the expenditure limit system was set below the inflation rate, that sector would be likelier to exceed its allocation. Alternatively, a payment mechanism may already constrain sector spending to rates below that sector's allocation. Depending on which policy is chosen, the sector might never benefit from the surplus it generates, but would instead subsidize other sectors with less effective payment mechanisms. For example, while the Volume Performance Standard system curbs spending for physicians' services, there are no similar constraints in place for the outpatient hospital sector.

As currently proposed, the failsafe budget mechanism is not consistent with the proposed Sustainable Growth Rate system. An anomaly would occur if spending for physicians' services were lower than anticipated, because these mechanisms would count any surplus savings twice. First, the failsafe budget mechanism would use the surplus savings to offset excess spending by other sectors. Then, the Sustainable Growth Rate system would use the same surplus to increase physicians' payment levels.

Avoiding incompatibility between the payment mechanisms and the systems of expenditure limits or targets is hard because diverse mechanisms reflect the differences in the types of services and modes of health delivery in each sector. One strategy to overcome this problem would build the requirements of the failsafe mechanism into each of Medicare's payment mechanisms. This approach is complex, however, and would be difficult to implement. Building controls for volume growth in other sectors would be hard, for instance, because physicians largely determine when and where services are provided.

Other Considerations

Two other important considerations in designing a system to constrain Medicare spending include establishing appropriate expenditure targets or limits and addressing the effects of regional variation. The Commission has addressed both of these issues in the context of its discussions on improving the Volume Performance Standard policy (PPRC 1993a).

First, to establish a more realistic and affordable goal for spending for physicians' services, the Commission has recommended linking the target rate of growth to a set percentage above the projected rate of growth of gross domestic product (GDP) per capita. This recommendation was adopted as part of the proposed Sustainable Growth Rate system. The target would also reflect inflation, changes in enrollment, and changes in spending because of law and regulations. As a result, the target would automatically reflect a broad range of potential changes such as increases in input prices or expansion of the scope of benefits.

The failsafe budget mechanism, on the other hand, would establish fixed spending amounts for each year through the year 2002. After 2002, it would limit annual per capita growth to 5 percent for the entire Medicare program. These limits provide no adjustment for inflation. If this rate were too high, the target could be lowered to more appropriate levels through legislation. But current budget rules make it difficult to raise the target if it becomes too restrictive, because they require spending increases to be offset either by increasing tax revenues or by making spending cuts elsewhere.

In addition, the failsafe budget mechanism might establish a lower average rate of growth for fee for service than for private risk-based plans overall. Annual increases to risk-based plans overall would be 5 percent per capita. By contrast, the fee-for-service limit would ensure that, for any year, spending growth never exceeded 5 percent per capita; spending below that rate would accrue to the Medicare program as additional savings. Consequently, overall spending in fee for service may be constrained to a lower rate of growth than for risk-based plans.

An alternative approach, which would allow comparable rates of growth, would replace the expenditure limit with an expenditure target of 5 percent per capita. That is, fee-for-service payment levels would be raised if spending growth rates were projected to be less than this target rate. Payment levels would be lowered if projections were higher than the target.

The approaches discussed so far have been restricted to national expenditure limits and targets, but constraining spending using national limits and targets can have adverse effects regionally. For example, populous areas with higher rates of per capita spending could cause a sector to exceed its allocation. The payment reductions that would ensue, however, would apply nationwide, penalizing providers in rural areas and in areas with low spending rates per capita. Addressing this issue in the context of national spending limits for the Medicare program as a whole is necessarily more complex and beyond the scope of this chapter. The Commission expects to address this issue in the coming year.

A CLOSER LOOK AT THE FAILSAFE BUDGET MECHANISM

The proposed failsafe budget mechanism establishes spending limits for the entire Medicare program, but controls spending by reducing payments to fee-for-service providers. Spending for all private Medicare risk-based plans (called MedicarePlus plans), would be constrained through capitated payments with prospectively specified annual increases. As a result, spending above the overall limits would be attributed to fee for service, so payments to fee-for-service providers would be reduced as needed to stay within the limits.

The failsafe budget mechanism would operate in five steps:

- First, it would set overall spending limits for the entire Medicare program.
- Second, it would determine the total fee-for-service spending limit by subtracting the spending for MedicarePlus plans.
- Third, it would calculate spending allocations for each of nine sectors (inpatient, home health, extended care, hospice, physicians, outpatient hospital, durable medical equipment and supplies, diagnostic tests, and other).
- Fourth, it would reduce current-year allocations to sectors based on a "lookback" provision if actual fee-for-service spending two years earlier had exceeded that year's spending limit.

- Fifth, it would compare projected spending to the fee-for-service spending limit. If projections showed that the limit would be exceeded, the failsafe budget mechanism would reduce payments in sectors with excess spending.

The rest of this section describes each of these five steps in detail, using simulation models of the system to illustrate how the failsafe mechanism would operate.

Setting Overall Spending Limits

If enacted, the failsafe budget mechanism would establish annual spending limits, called the Medicare benefit budget. The overall spending limit would be $194.2 billion in 1996 and $206.3 billion in 1997 (Table 13-4). Although the mechanism would set spending limits for 1996 and 1997, it would not begin to affect payments until 1998. After the year 2002, the Medicare benefit budget would be allowed to grow annually at 5 percent per capita.

Setting the Spending Limit for Fee for Service

Under the mechanism, the spending limit for fee for service would be determined by subtracting anticipated spending for the MedicarePlus plans from the overall Medicare benefit budget (Table 13-4). In 1998, the Medicare benefit budget would allow $217.8 billion in total spending. Spending for MedicarePlus plans is estimated at $34.7 billion, so the fee-for-service limit is $183.1 billion.

The amount of spending available under fee for service would depend on how many beneficiaries enroll in the MedicarePlus plans and on their capitated payments. Models of the failsafe budget mechanism depend

Table 13-4. Example of Calculation of the Fee-for-Service Spending Limit (in billions of dollars)

	Medicare Benefit Budget	-	MedicarePlus Spending	=	Fee-for-Service Spending Limit
1996	$194.2		$15.2		$179.0
1997	206.3		18.1		188.2
1998	217.8		34.7		183.1
1999	229.2		40.7		188.5
2000	247.2		46.6		200.6
2001	266.4		54.1		212.3
2002	289.0		62.9		226.1
2003	307.2		72.2		235.0
2004	327.2		82.5		244.7
2005	348.5		93.8		254.7

SOURCE: Physician Payment Review Commission analysis.

NOTE: This example assumes that beneficiaries are enrolled in their plan for 12 months and that enrollment in the MedicarePlus plans will be 25 percent by the year 2002. It also uses Part B enrollment rates, and a monthly capitation rate that reflects the demographic and geographic characteristics of the Medicare program as a whole.

on various assumptions of projected spending for the MedicarePlus plans. While different assumptions produce substantially different estimates of fee-for-service spending limits per capita, methodological limitations of the failsafe budget mechanism can be illustrated regardless of these assumptions. Hence, assumptions were made to provide favorable estimates that increased the spending limit for fee for service. For example, the model assumes no risk selection.[3] Based on these favorable assumptions, the spending per capita available under fee for service would be higher than that for the MedicarePlus plans ($5,397 for fee for service in 1996 compared to $5,252 for MedicarePlus plans) (Table 13-5).

Allocation of Spending across Sectors

In addition to setting overall limits for fee-for-service spending, the failsafe budget mechanism would set limits for each of the nine sectors. The conference agreement establishes annual growth rates for each sector for 1996 to 2002. These growth rates would be multiplied by the 1995 actual spending for each sector to obtain relative spending levels.[4] Next, the relative spending levels for each sector would be divided by the total spending for all nine sectors to determine the proportional spending share (Table 13-6). Finally, these sector proportions would be multiplied by the fee-for-service spending limit to obtain the sector's allocation.

Table 13-5. Average Allowed Spending per Enrollee for MedicarePlus and Fee for Service (dollars)

	MedicarePlus	Fee for Service
1996	$5,252	$5,397
1997	5,485	5,656
1998	5,746	5,908
1999	6,004	6,144
2000	6,243	6,592
2001	6,600	7,051
2002	6,969	7,615
2003	7,318	8,022
2004	7,684	8,472
2005	8,068	8,944

SOURCE: Physician Payment Review Commission analysis.

NOTE: The example assumes that beneficiaries are enrolled in their plan for 12 months and that enrollment in the MedicarePlus plans will be 25 percent by the year 2002. It also uses Part B enrollment rates, and a monthly capitation rate that reflects the demographic and geographic characteristics of the Medicare program as a whole.

[3] The model uses an estimate for the national average MedicarePlus capitation payment, a monthly capitation rate that reflects the demographic and geographic characteristics of the Medicare program as a whole, and projections of Part B enrollment rates. It also assumes that 25 percent of Medicare beneficiaries will be enrolled in the MedicarePlus program by the year 2002. Projected growth of fee-for-service spending reflects CBO's March 1995 baseline. In addition, the failsafe budget mechanism was modeled at a national level rather than, for instance, the county level at which capitation payment rates are set.

[4] The simulation model uses CBO's projection of 1995 spending per sector from its 1995 March baseline as an estimate of actual spending for 1995.

The Lookback Provision

Although each sector's allocations would be initially predetermined, the lookback provision would make additional adjustments as needed to keep spending within the overall limits. Each year, the Secretary would project each sector's fee-for-service spending and reduce payments if the projections showed that the spending limits would be exceeded. If the Secretary's projections were too low and payments were not reduced sufficiently, actual spending could exceed the limits. The lookback provision, therefore, would protect against projections that were too low, by reducing sector allocations when actual spending exceeded the limits.[5]

Because this provision considers actual spending, it incorporates a two-year delay to allow for the completeness of claims data. For example, the lookback provision would adjust the sector allocations for the year 1998 based on actual spending in 1996.

The lookback provision would reduce sectors' allocations when actual fee-for-service spending two years earlier exceeded its limit. A sector's allocation would be reduced by its proportion of excess spending relative to other sectors, multiplied by the total amount that fee-for-service spending exceeded its limit (Table 13-7). As illustrated, the 1996 fee-for-service limit is $176.1 billion, and actual spending is $180.5 billion. The total amount of excess spending is $4.4 billion. Eight of the nine sectors exceed their allocations by a total of $4.8 billion, except the outpatient hospital sector which had a surplus of $0.4 billion. For each of the sectors with excess spending, the proportional amount of excess spending is calculated. The inpatient hospital sector

Table 13-6. Shares of Fee-for-Service Spending under the Failsafe Budget Mechanism, by Service Sector (percentage)

Service Sector	1996	1997	1998	1999	2000	2001	2002
Inpatient Hospital	45.4%	43.9%	42.8%	41.8%	40.8%	39.7%	38.5%
Physicians	20.0	20.1	20.1	20.2	20.4	20.6	20.9
Outpatient Hospital	6.5	6.8	7.1	7.5	7.9	8.3	8.8
Home Health	9.4	9.9	10.1	10.2	10.2	10.2	10.1
Extended Care*	5.9	6.0	6.1	6.1	6.1	6.1	6.1
Hospice	1.4	1.5	1.7	1.8	1.8	1.9	1.9
Diagnostic Tests	2.9	2.9	3.0	3.1	3.2	3.3	3.4
Equipment and Supplies	1.8	1.9	2.0	2.1	2.2	2.3	2.4
Other	6.8	6.9	7.0	7.3	7.5	7.7	7.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

SOURCE: Physician Payment Review Commission analysis of conference agreement, which uses Congressional Budget Office estimates of 1995 spending from the March 1995 baseline.

* Includes skilled nursing facilities.

NOTE: Percentages may not sum to 100 percent due to rounding.

[5] The lookback provision makes no adjustments for projected spending that was too high and that may have led to unnecessary payment reductions.

accounts for $1.7 billion of the $4.8 billion in excess spending, so that sector's share of the excess is 35 percent. These proportions are then applied to the total $4.4 billion excess ($4.8 billion minus $0.4 billion). The inpatient hospital sector's 1998 allocation would be reduced by $1.54 billion.

Payment Reductions

The failsafe budget mechanism would determine whether payment reductions are needed to hold Medicare fee-for-service spending below the spending limits. The Secretary would be required to project how much each sector would spend in the coming year, and whether the fee-for-service spending limit would be exceeded. If projections showed that the limit would be exceeded, the proportion of excess spending attributable to each sector would be calculated. Then, payments within sectors with excess spending would be prospectively reduced by 133.3 percent of the product of the sector's projected proportion of excess and the total amount that fee-for-service spending is projected to exceed its limit. For example, if the mechanism had to recoup an excess of $1 billion from a sector, payments would be lowered so that spending for the sector would be reduced by $1.3 billion.[6]

Table 13-7. Example of How Lookback Provision Would Reduce 1998 Service Sector Allocations Based on 1996 Actual Spending (in billions of dollars)

Sector	1996 Actual Spending	1996 Fee-for-Service Spending Allocations	1996 Excess Spending	Sector's Portion of 1996 Excess Spending	1998 Allocation Reduction
Inpatient Hospital	$81.6	$79.9	$1.7	0.35	$1.54
Physicians	36.5	35.3	1.2	0.25	1.10
Outpatient Hospital	11.0	11.4	-[a]	0.00	0.00
Home Health	17.2	16.5	0.7	0.15	0.66
Extended Care[b]	10.6	10.3	0.3	0.06	0.26
Hospice	2.5	2.4	0.1	0.02	0.09
Diagnostic Tests	5.2	5.1	0.1	0.02	0.09
Equipment and Supplies	3.3	3.2	0.1	0.02	0.09
Other	12.6	12.0	0.6	0.13	0.57
Total	180.5	176.1	4.8[a]	1.00	4.40

SOURCE: Physician Payment Review Commission analysis.

[a] In this example, the sector for outpatient hospital services had no excess spending in 1996, but had a surplus of $0.4 billion. This $0.4 billion surplus offsets the $4.8 billion excess spending, bringing it down to $4.4 billion.

[b] Includes skilled nursing facilities.

NOTE: In this example, total actual spending of $180.5 billion exceeds the fee-for-service spending limit of $176.1 billion, leading to a total excess of $4.4 billion that must be made up through payment reductions. Next, each sector's share of excess spending is calculated based on the excess in each sector and the sum of excess spending for sectors that exceeded their allocation ($4.8 billion in this case). Finally, each sector's share of excess spending is multiplied by the total amount of excess spending to determine the reduction in the sector's allocation for 1998.

[6] The rationale and implications of the 133.3 percent reduction are discussed in the next section.

In addition to the 133.3 percent reduction, the Secretary would also be required to incorporate additional reductions as necessary to ensure spending stays within the limits. In particular, the payment levels would be further reduced in order to offset potential spending increases caused by providers' and beneficiaries' responses to lower payments. That is, reductions for behavioral responses are made on top of the 133.3 percent reduction.[7]

The failsafe budget mechanism would reduce payment levels if spending limits were to be exceeded, but would have no provision for raising them. As a result, any payment increases within a sector would depend on that sector's payment mechanism, and any updates would be applied to the new lower payment levels. For example, the Sustainable Growth Rate system for physicians would provide for changes in inflation and real GDP growth per capita, but the updates would apply to the lower payment level established by the failsafe budget mechanism. Payments for clinical laboratory services would remain at the reduced level set by the failsafe budget mechanism through 2002, because the conference agreement would freeze inflation updates for these services.

LIMITATIONS OF THE FAILSAFE BUDGET MECHANISM

Although the failsafe budget mechanism establishes spending limits to ensure scored savings of $270 billion, its implementation could lead to larger payment reductions than needed to meet these budget goals. Because the payment reductions would be permanent, the failsafe budget mechanism might reduce a sector's future payments as well as those for the year in which the sector had excess spending.[8]

The failsafe mechanism could be modified so that its reductions would more closely reflect the intended budget goals. This would require having payment reductions in effect for one year only, and increasing payments to levels they would have achieved had the mechanism not been triggered. If these higher rates led to excess spending, the failsafe mechanism would be invoked again.

Without this modification, fee-for-service spending levels per capita would likely be well below those required to meet the budget goals (Table 13-8). In 1998, the first year that the mechanism could be triggered, it would reduce fee-for-service spending to $179 billion. The mechanism would reduce payments to recoup spending above the 1996 and 1997 spending limits, which it would accomplish through the lookback provision. This reduction, however, would be larger than needed to meet budget goals. A policy that would more appropriately reflect the budget goals would omit the 133.3 percent offset and would make payment reductions that apply for one year only. Under this policy, spending in 1998 and

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7 The model presented here does not include these additional reductions.

8 CBO's scoring of the failsafe budget mechanism was based on the Medicare benefit budget rather than on how the mechanism would actually operate. As a result, the scored savings do not reflect the additional savings that would accrue from the permanent payment reductions. In addition, CBO assumed that the mechanism would never be fully effective, and therefore would achieve no more than 75 percent of the savings expected from the Medicare benefit budget. Hence, the mechanism includes an adjustment that makes payment reductions larger by 133.3 percent to offset this anticipated shortfall.

Table 13-8. Estimated Spending under Various Policy Refinements of the Failsafe Budget Mechanism (in billions of dollars)

	Fee-for-Service Spending Limit	Proposed Failsafe Budget Mechanism*	Policy Refinements		
			With 133.3 Percent, One-Year Reduction	Without 133.3 Percent, Permanent Reduction	Without 133.3 Percent, One Year Reduction
1996	$179.0	$180.5	$180.5	$180.5	$180.5
1997	188.2	192.5	192.5	192.5	192.5
1998	183.1	179.0	179.0	181.7	181.7
1999	188.5	182.9	179.0	184.2	184.2
2000	200.6	193.9	196.9	195.3	200.6
2001	212.3	205.4	208.3	206.9	212.3
2002	226.1	217.1	222.5	218.7	226.1
2003	235.0	225.5	217.7	234.8	235.0
2004	244.7	241.4	223.9	244.7	244.7
2005	254.7	253.4	230.0	254.7	254.7

SOURCE: Physician Payment Review Commission analysis.

NOTE: The example assumes that beneficiaries are enrolled in their plan for 12 months and that enrollment in the MedicarePlus plans will be 25 percent by the year 2002. It also uses Part B enrollment rates, and a monthly capitation rate that reflects the demographic and geographic characteristics of the Medicare program as a whole.

* The failsafe budget mechanism, as proposed in the conference agreement would make permanent payment reductions and would reduce payments by 133.3 percent by the amount needed to meet the spending limit.

1999 would be reduced to $181.7 billion and $184.2 billion, respectively, to recoup excess spending for 1996 and 1997. Thereafter, this policy would reflect the fee-for-service spending limit exactly.

Other modifications could improve the failsafe mechanism as well. First, as with the Sustainable Growth Rate system for physicians, comparisons could be made between cumulative actual spending and cumulative budget limits. This change would eliminate the need for the two-year delay and the lookback provision. It would also credit surpluses (amounts of spending below the limits) to future years. In the proposed failsafe budget mechanism, if fee-for-service spending falls below the limits, the lookback provision does not increase spending allocations by the surplus amount.

Finally, the failsafe budget mechanism relies extensively on projections of spending and enrollment in MedicarePlus plans. While the lookback mechanism would make adjustments if these projections are too low, there is no adjustment for projections that are too high. If projections are too high, permanent payment reductions would be taken although total actual Medicare spending would have stayed below the limits. As a result, fee-for-service Medicare spending would be reduced well below the limits needed to meet budgetary goals.

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Geographic Adjustment of Medicare Payments

Medicare payments to providers and health plans have always differed nationwide. To devise payment policies with geographic variation, policymakers must designate the geographic units within which a common payment level should prevail and choose some basis for adjusting payments across these geographic units. For several years, the Commission has studied these issues in relation to fee-for-service payments to physicians and to Medicare's risk program. Some of its recommendations in this area may merit review within the context of changes in Medicare and the health care system. These issues have been also explored extensively by the Health Care Financing Administration (HCFA) and others.

Historically, geographic payment policies have been analyzed separately for Medicare's fee-for-service and risk programs—an approach that may be appropriate, given differences in the unit of payment and the sources of geographic variation in costs faced by providers and managed-care plans. But even if it is logical for these policies to differ, it is nonetheless important to understand how they might affect the relationship between the two programs at the local level.

This chapter starts with a brief conceptual discussion of the key sources of geographic variation in per capita health expenditures and how these relate to geographic adjustment of payments under both fee-for-service and capitated payment. It then reviews current Medicare policies and related issues. The last section briefly discusses the relationship between the programs' geographic policies.

The chapter addresses the two explicit policy decisions concerning geographic adjustment of payments—payment areas

This chapter includes:

- *Sources of geographic health expenditure variation*
- *Implications of variation for adjustment of payments to providers and plans*
- *Current Medicare geographic payment policies for the risk program and fee-for-service physician payment*
- *Relationship between Medicare fee-for-service and risk program geographic payment policies*

and adjusters. It deals only with payment policy, which means quite different things under fee-for-service and managed care. Within the fee-for-service sector, payment policy sets payment levels for individual services, while in the managed-care context it sets per capita expenditures. This difference in the unit of payment makes the comparison of policies more complicated than it may first appear. Medicare geographic payment policies within the fee-for-service and risk programs are just one aspect of a larger policy issue, namely how these two programs relate to each other nationally and in local markets, a topic beyond the scope of this chapter. The Commission plans to explore this broader issue next year.

GEOGRAPHIC VARIATION IN PER CAPITA HEALTH EXPENDITURES AND ADJUSTMENT OF PAYMENTS

Per capita health expenditures are determined by the price of health care services and the quantity of care consumed, both of which vary across the nation. Geographic differences in the price of health care are determined by various factors, including local wage rates, prices for inputs such as supplies and office space, and provider supply. Geographic variation in quantity, as captured by per capita utilization, is also caused by a variety of factors, among them differences in demographic characteristics and health status of local populations, provider practice patterns, and consumer preferences. The wider availability of information about practice standards, guidelines, and outcomes may mitigate some differences in utilization. On the other hand, with the introduction of new technology and other changes in medical practice, new sources of variation in utilization are likely to emerge.

From a policy perspective, it is helpful to categorize utilization as nondiscretionary or discretionary, since it may be appropriate for policies to accommodate the two types differently. It is difficult, however, to determine whether utilization is discretionary and could or should be reduced. In fact, whether utilization is discretionary is a matter of degree. For the sake of exposition, however, the following discussion of geographic variation in per capita health expenditures distinguishes between discretionary and nondiscretionary utilization, although this is an oversimplification.

As they develop policies to adjust payments for geographic differences in per capita expenditures, policymakers must consider the role played by local prices as well as discretionary and nondiscretionary utilization. Typically, payers have tried to develop payment policies that insulate plans and providers from factors beyond their control. For example, since local hospitals typically must accept local nurse wages as given, payers may adjust fee-for-service hospital payments for differences in these wages.

This section briefly discusses the relationship between the sources of geographic variation in per capita expenditures and the development of geographic payment policies. For any single payer, patient access will depend on setting payment rates sufficiently high that providers or plans will be willing to serve the payer's patients.

Because fee-for-service and capitated systems establish payments for different units of services, each system differs in how it reflects certain sources of geographic variation in per capita spending and in the specific payment policies that may be appropriate. Both fee-for-service providers and capitated plans

must pay for any local input price variation that is not included in payments they receive. Under traditional fee-for-service arrangements, payment is made for each service delivered, putting the payer at risk for variation in utilization. Capitated payments, by contrast, cover both the cost and number of services provided, putting plans at risk for any use of services beyond that compensated for by the payment. These differences should be considered when choosing areas and adjusters for each type of payment.

Adjusting Payments for Variation in Local Prices

Since both fee-for-service providers and health plans cannot typically set prices in local labor and goods markets, payers may choose to adjust their payments to each in order to reflect local prices. For such price adjustments to insulate providers and plans from local price changes, price adjusters should focus as much as possible on prices for appropriate inputs and must be revised as conditions change over time. Use of wage data for too broad a worker category or from the wrong time period will lead to payment adjustments that do not accurately match the change in demands on providers' and plans' resources. For example, if the demand for nurses exceeds the local supply, then the local nurse wage will rise relative to the national nurse wage and to other local wages. The higher local wage increases the local nurse supply, thereby slowing the growth in nurses' salaries. If payers' efforts to adjust payments for changes in local input prices are to insulate providers and plans from such wage swings, their price adjustments must reflect the relative change in nurse wages in a timely way. At the same time, providers and plans may be concerned if payments appear to be volatile over time. Therefore, efforts to track prices accurately must be balanced against providers' and plans' interest in payment stability and predictability.

Because local price adjustments need to focus on the appropriate mix of inputs, price indexes created specifically to adjust capitation and fee-for-service payments to different types of providers should differ from one another. Compared with physician practices, hospitals have a different employee mix and buy different types and amounts of equipment and supplies. Consequently, a price index appropriate for adjusting fee-for-service hospital payments is not appropriate for physician payments. Similarly, managed-care plans and fee-for-service providers do not use the same mix of labor and supplies. A different price adjuster is thus appropriate for capitated payments.

Since input price adjustment is meant to reflect local economic conditions, the definition of payment areas in which a particular price index is appropriate should be consistent with generally used notions of local markets, such as metropolitan areas. To define areas for payment adjustment, hospital markets or managed-care markets may be less relevant than labor and goods markets, which typically are larger than these health care specific markets. Existing market definitions that reflect local economic activity (as reflected in goods distribution patterns, newspaper circulation areas, and commuter patterns) might be useful for this purpose.

Adjusting Payments for Utilization Variation

As mentioned above, there are two sources of geographic variation in service utilization: discretionary sources such as provider styles, and nondiscretionary ones like patient characteristics and health status.

Though it is generally agreed that providers and plans should be insulated from variation stemming from the latter source, most payers would like to reduce the former.

Traditional fee-for-service payment holds individual providers harmless for utilization variation regardless of the source. While this should facilitate access for patients who use many health care services, it is one of the perceived flaws of fee-for-service payment since it gives providers no incentives to constrain unnecessary utilization. Because payers are at risk for such discretionary utilization, they have developed a range of strategies, including utilization review and pre-utilization authorization, to reduce this. Such policies generally are not linked to payment policy and do not vary geographically.[1] Consequently, geographic adjustment of fee-for-service payment is usually based on input price considerations and does not address the role that utilization variation plays in geographic differences in per capita expenditures.

Capitated payment presents different issues because it explicitly puts plans at risk for utilization variation. While this creates incentives for plans to reduce the level and variation in utilization due to discretionary factors, it may also lead them to avoid enrolling those likely to have high levels of nondiscretionary utilization. To reduce the latter incentive, some payers adjust payments to plans for the health status of individual enrollees. Although this should theoretically insulate plans from nondiscretionary utilization variation, available risk adjusters do not fully account for the role of inherent health-risk differences among enrollees in utilization differences. As a result, it may be appropriate to use geographic payment policies to augment incomplete risk adjustment. To the extent that differences in utilization vary geographically, either capitated payment adjusters or payment areas could be designed to reduce plans' potential loss from adverse selection and their incentive to avoid enrollees with poor health status.

It is difficult to use geographic payment policies to help compensate for these nondiscretionary utilization factors without also adjusting payments for variation in discretionary utilization. For example, use of fairly small payment areas for capitated payments may help compensate for the shortcomings of available risk adjusters to the extent that small areas capture relatively homogenous populations. At the same time, however, small areas may also include homogeneous provider practice styles. Using larger areas may create incentives for those in high-use areas to revise their practice patterns or to move away from high-cost areas. In the short run it may be appropriate to allow payments to reflect such variation so that plans can enter markets and develop care-management processes. But in the longer run, such an approach might reduce plans' incentives to decrease discretionary utilization levels and variation. The choice of payment areas and adjusters for capitated payments may need to consider variation in both input prices and utilization, although the latter ultimately should target the role of nondiscretionary factors.

GEOGRAPHIC ADJUSTMENT OF MEDICARE FEE-FOR-SERVICE PHYSICIAN PAYMENTS

Medicare's geographic adjusters for physician payment have changed since the Medicare Fee Schedule was implemented, but payment areas have remained largely the same. The previous charge-based payment

[1] Because some payers have processes that are implemented regionally, utilization review may acknowledge some geographic variation in utilization.

system essentially allowed physicians to create a self-determined pattern of payment variation. Within Medicare, the geographic areas across which charge-based payments varied were determined by carriers, but the pattern of variation was, in effect, determined by physicians through charges. Under the fee schedule, Medicare payments to physicians are explicitly adjusted for geographic variation in input prices. For each of the three components of the fee schedule—physician work, practice expense, and malpractice expense—there is a corresponding geographic practice cost index (GPCI). Separate GPCIs are defined for each fee schedule payment area. In addition to the geographic adjustment policies discussed here, physician payment levels under the fee schedule are also affected by the link between payment levels and utilization growth created by the Volume Performance Standard (VPS) system. The Medicare fee-for-service physician payment policies described below differ from those for other types of providers.

Fee Schedule Payment Areas

As required by the Omnibus Budget Reconciliation Act of 1989 (OBRA89), the payment areas under the fee schedule are the same as those that were part of the previous customary, prevailing, and reasonable (CPR) payment policy.[2] Under the CPR methodology, Medicare carriers developed payment screens based on charges from physicians within each locality. The carriers defined these localities on the basis of various economic, political, and administrative considerations. By the time the fee schedule was implemented, the size and number of localities within each state varied widely, from 1 to over 30. In general, localities respect established geographic boundaries such as counties, cities, or metropolitan areas, although some divide counties.

The continued use of payment areas that are defined so differently in various states is incongruous with the systematic approach to payment under the fee schedule. The Commission and others have studied alternative approaches to defining payment areas since before the fee schedule was implemented (see Chapter 9). Because analysts and policymakers agree on the appropriateness of using statewide payment areas for those states without much price variation, these studies typically have looked first at which states should be considered as statewide areas.

A variety of approaches have been explored and recommended for creating substate areas in those states with considerable input price variation. In 1991 the Commission recommended that within these states, metropolitan areas should be grouped into payment areas according to four population categories and the remaining nonmetropolitan areas should define a fifth category. A recent analysis by Health Economics Research, Inc. under contract to HCFA proposes an approach based on retaining only those payment areas in which GPCIs surpass the rest-of-state average GPCI by more than some threshold amount.

Geographic Adjusters for Medicare Fee-for-Service Physician Payments

Before the fee schedule was implemented, the Commission was asked to analyze the appropriateness of the GPCIs that HCFA proposed for use in adjusting payments across areas. There are three separate

[2] Since implementation of the fee schedule, physicians in several states have successfully petitioned to have their states redefined as statewide payment areas.

GPCIs, corresponding to the three components of the fee schedule. OBRA89 requires HCFA to update the GPCIs every three years; the first update was put in place on schedule in 1995 and was based on 1990 census data (HCFA 1994). In addition to using more recent data, the new GPCIs reflect some technical improvements (PPRC 1995).

The physician work GPCI is based on professional wage data from the decennial census. As specified in OBRA89, only 25 percent of the variation in these wages is reflected in the work GPCI.

The practice expense GPCI is constructed from price indexes for employee wages, rent, and miscellaneous equipment and supplies. The use of residential rents as measured by the Department of Housing and Urban Development (HUD) as a proxy for office rent has been the most controversial element of this GPCI. HCFA has been working to identify alternatives to the residential rent data, but has not found a source that provides reliable information for the entire nation (HCFA 1994).

The malpractice GPCI is based on data collected and maintained by HCFA. The current values reflect premiums for:

- 20 specialties,
- representative types of coverage ($1 million/$3 million), and
- the most common insurers in each state—typically encompassing more than 80 percent of each state's market (HCFA 1994).

These data are more representative than those underlying the malpractice GPCI that was in effect from 1992 to 1994.

When the Commission investigated the GPCIs before the fee schedule was implemented, it concluded that HCFA was using the most appropriate data available.[3] Although many are concerned that use of residential rents is an inappropriate proxy for office rental costs, the Commission has concluded that the two are likely to be highly correlated and the absence of commercial rent data nationwide justifies the continued use of the HUD residential rent data.

The Secretary of Health and Human Services reported to the Congress this year, as required, on likely approaches to the next GPCI update, which will occur before new decennial census data are available. The wage data used in both the physician work GPCI and the practice expense GPCI pose the key problem for these inter-census updates, since most other elements of the GPCIs are available more frequently. According to the report, HCFA had a contractor explore potential sources for these wage data but made no decision about how to update them. HCFA has let a new contract under which activities for the next GPCI update have already begun. The Commission has consistently suggested that any analysis of new payment

[3] The Commission suggested a few improvements, such as use of the 1990 census data and better data on malpractice premiums, which were addressed when the GPCIs were updated for 1995.

areas, discussed further in Chapter 9, include as one of its criteria for assessing potential definitions the availability of data for these periodic GPCI updates.

GEOGRAPHIC ADJUSTMENT OF MEDICARE CAPITATED PAYMENTS

Geographic variation in Medicare capitated payments is now tied directly to that of the Medicare fee-for-service payments. The adjusted average per capita cost (AAPCC), which is the basis for payment in the Medicare risk program, is based on five-year average historical Medicare expenditures per fee-for-service beneficiary in each county. Because the county AAPCCs are for a standardized beneficiary, they do not reflect inherent beneficiary characteristics that influence expected health utilization.[4] A separate process is used to adjust the monthly AAPCC-based payments to plans based on the utilization risk represented by plans' actual enrollee mixes. Thus, current policy allows capitated payments to reflect variation in Medicare fee-for-service payments caused by discretionary and nondiscretionary utilization variation as well as price variation.[5] The price variation reflected in the AAPCC is determined by Medicare's geographic payment policies for the fee-for-service program.

Use of fee-for-service payments as the basis for capitated payments has been criticized because it passes the costs of inappropriate utilization variation along in capitated payments. In fact, some policymakers have concluded that this link between the fee-for-service and risk programs should be severed and have been exploring alternative approaches to setting payments in the risk program. The degree to which proposed policies reflect per capita utilization differences will be determined by some policy judgment about the appropriate strength of incentives to plans to modify the level and variation in utilization due to more discretionary factors. As with fee-for-service geographic payment policy, resulting geographic variation in capitated payments will reflect decisions about the areas within which a payment rate should prevail and the strategy for adjusting rates across these payment areas.

Medicare Capitated Payment Areas

Counties are defined as the payment areas under the current risk-contracting program. Because many plans serve more than one county, they face multiple Medicare payment rates within their service areas. As mentioned above, using relatively small payment areas, such as counties, is thought to help compensate for incomplete risk adjustment insofar as they capture relatively homogeneous populations. Improved risk-adjustment processes would mitigate the need for geographic policies to address nondiscretionary sources of utilization variation. Current Medicare payment policies take advantage of any correlation between county of residence and health status. Use of small areas has disadvantages, however, including erratic payment levels over time in some counties.

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[4] A standardized beneficiary is someone who is expected to incur the average per capita health care costs, that is, who has a risk factor equal to one. Counts of standardized Medicare beneficiaries in a county are obtained by multiplying the number of beneficiaries by their applicable risk factors.

[5] See Chapter 5 for a more detailed discussion of Medicare capitation payment policy and related issues.

Use of payment areas that consist of multi-county areas has been suggested as an approach to reduce payment volatility and to smooth variation in payment rates across counties in a market area. This approach would lose some of the population homogeneity of counties by moving to larger, more diverse population bases. The loss in capturing some degree of local price and nondiscretionary utilization variation would be offset by smoothing discretionary utilization differences over a broader area.

The recent Senate proposal for Medicare restructuring suggested using regional payment areas for health plans. Under this proposal, each metropolitan statistical area (MSA) would be considered a payment area and each state's non-MSA counties would define a payment area. The congressional conference agreement (H.R. 2491), however, retained counties as payment areas, while allowing states to submit alternative proposals for payment areas within their jurisdictions. The Administration's proposal also would retain county payment areas.

Geographic Adjusters for Capitated Payments

The current AAPCC payment method establishes a national average payment amount and then applies geographic adjusters to the national amount to obtain local payment rates.[6] The national payment amount is the U.S. per capita cost (USPCC) for fee-for-service beneficiaries, which is then adjusted for each county by the ratio of per capita costs for fee-for-service beneficiaries residing in the county to the USPCC. As discussed above, the resulting county AAPCC rates reflect a mix of nondiscretionary and discretionary sources of variation in utilization, which could diminish plans' incentives to change enrollee and provider behavior. Although it is difficult to determine how much variation in utilization should be reflected in payments, adjustment of capitated rates for local price variation is appropriate.

A variety of strategies have been suggested for reducing the amount of payment variation due to local differences in service utilization. The most extreme approach would be to adjust the national average amount only for differences in local input prices, thus removing all service use variation from payments. Because it is uncertain, however, how much service utilization variation is appropriate or can be ignored without stifling expansion of Medicare managed care, more moderate methods that allow payments to reflect some variation in per capita utilization have been preferred. These include weighted averages of local areas' capitation rates and input-price-adjusted national rates (blended rates), trimming very high or low payment rates (floors and ceilings), or differential updates of local rates based on how much they differ from the payment areas' input-price-adjusted national rates. These options use Medicare hospital wage indexes and fee schedule GPCIs for input-price adjustment (see Chapter 5).

Legislative proposals made during 1995 have included several such methods. The conference agreement would phase in blended rates for health plans over a six-year period, at which time payment rates would be based on 70 percent of the local rates and 30 percent of the input-price-adjusted national rates. It also would raise low payment rates to a $300 floor in 1996 and to a $350 floor in 1997. The $350 floor would be retained and updated along with payments in later years. Under the Administration's proposal, a

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[6] Separate AAPCC rates are calculated for Medicare Part A and Part B services. The sum of the Part A and Part B AAPCC rates is the county AAPCC rate referred to in this discussion, except where otherwise noted.

payment floor and ceiling of 80 percent and 150 percent of the national average rate, respectively, would apply to only the Part B AAPCC rate for each county. Medicare would share with plans the amount in excess of the ceiling in decreasing shares over a five-year period, until the Part B payment would be limited to the ceiling in the fifth year.

RELATIONSHIP OF GEOGRAPHIC ADJUSTMENT OF FEE-FOR-SERVICE AND CAPITATED PAYMENTS WITHIN MEDICARE

It is important to consider how geographic adjustment of payments within Medicare's fee-for-service and risk programs relate to each other and how this may affect beneficiaries' choices in a given community. The current link between the two programs has several implications. First, as described above, it may reduce incentives to managed-care plans to curb discretionary use of health care services. Second, changes in fee-for-service payment policies affect variation in capitation payments. For example, the geographic variation in AAPCC-based capitation payments will change in the next few years because of the geographic redistribution of physician payments now occurring under the Medicare Fee Schedule.

This year policymakers have started to consider the relationship between Medicare's fee-for-service and risk programs at the local level. With regard to geographic policies, the current use of county-level AAPCC-based payments means that the risk program reflects fee-for-service policies exactly because payments are derived directly from fee-for-service payments.[7] If capitation payment policies are changed, however, it seems unlikely that they can continue to relate logically to the disparate geographic policies for different types of providers within the fee-for-service program.

Aside from the issue of the relationships among current policies, though, is the broader issue of whether there are legitimate reasons for capitated rates to vary differently than fee-for-service rates do. In the short run, the limitations of risk adjusters suggest that geographic policies for capitated rates should consider more than local price variation, but not necessarily all fee-for-service utilization variation. As risk adjusters that explain more of the unavoidable differences in consumer utilization rates become available, then geographic policies for the risk program could focus more closely on the role of input price variation and draw on adjustment approaches used in the fee-for-service program.

Ultimately, the continued use of different geographic policies in the various parts of the fee-for-service program will make it difficult to analyze the relationship between the risk and fee-for-service programs. Next year, therefore, the Commission plans to study Medicare's geographic policies within the various fee-for-service sectors. If the county AAPCC is retained as the basis for capitation payments, the effect of current fee-for-service sector-specific policies on variation of the AAPCC will be addressed. If capitation payment policies are changed, the relationship between the new capitation payments and those in the various fee-for-service sectors will be considered.

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[7] The one exception to this is where physician payment areas subdivide a county, in which case the county-level AAPCC will reflect a blend of the fee schedule geographic adjustment factors from the subcounty areas.

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Risk Selection and Risk Adjustment in Medicare

The growth in Medicare managed-care enrollment and the potential for new insurance options for Medicare beneficiaries make risk selection an increasingly important issue. Some plans may draw beneficiaries whose health care costs are expected to be low (favorable selection); others may attract beneficiaries with complex medical problems and high costs (adverse selection).

For three reasons, the Medicare program must adjust its capitation payments to reflect risk selection, paying less to plans attracting favorable selection and more to plans with adverse selection. First, Medicare's costs would increase if it paid a managed-care plan more than it would have cost to treat the plan's enrollees in the traditional Medicare fee-for-service program. Second, competition among health plans does not work as well without adequate risk adjustment. A poorly performing health plan may prosper if it attracts enough low-cost beneficiaries, while an efficient plan may struggle if burdened with many high-cost patients. Finally, a lack of risk adjustment may give some plans an incentive to avoid treating the most severely ill, thereby creating barriers to care for beneficiaries with costly health problems.

Medicare's risk-adjustment method has been widely criticized as inadequate. Medicare uses information on beneficiaries' demographics to adjust capitation rates. For example, because health care costs generally increase with age, Medicare pays higher capitation rates to plans that enroll older beneficiaries. But age, gender, and the other factors currently in use appear to account for very little of the risk selection that occurs.

This chapter includes:

- *Beneficiaries' costs before HMO enrollment and after leaving an HMO*
- *Beneficiaries' experience during their HMO enrollment*
- *How well risk adjustment and risk sharing explain group-level differences in costs*
- *Policy discussion and work plan*

Various techniques could be used to improve the current mechanism for risk adjusting payments to plans. Medicare has funded the development of several different approaches using diagnosis information to predict beneficiaries' health care costs. Studies demonstrate that these diagnosis-based risk adjusters offer a substantial improvement over today's adjustment methods. In addition, methods that would pay plans partly on a capitation basis and partly on a fee-for-service basis would substantially reduce overpayments or underpayments caused by biased selection.

Medicare's adoption of these approaches may be impeded by a variety of factors. Diagnosis-based risk adjusters require significant new data from health maintenance organizations (HMOs), potentially in a form comparable to existing Medicare claims. Implementing and auditing a new data system could be quite time-consuming. Further, options that would make some payments on a fee-for-service basis lead to objections from some HMOs, which are oriented toward providing care in a capitated environment. In all cases, testing would be necessary to see whether the new methods to address biased selection had significant negative effects or resulted in unexpected changes in the behavior of plans, providers, or beneficiaries.

The complexity of the biased selection issue and the lack of data make this a difficult policy issue for which there is currently no definitive answer. But the issue is becoming more important as Medicare managed-care enrollment increases and expansion of health plan options for beneficiaries is contemplated. Since testing and implementing new risk-adjustment methods may take some time, demonstrations of these new methods should proceed.

This chapter examines evidence of risk selection in Medicare's risk-contracting program and describes some proposed approaches to improve risk adjustment of payments to plans. The first section looks at the experience of Medicare beneficiaries before they enrolled in an HMO and after they disenrolled. A literature review shows that beneficiaries who joined HMOs in the 1980s had low health care costs prior to enrollment, while those who disenrolled from HMOs had both high costs and high mortality rates. Based on the Commission's analyses, this is still true in the 1990s. Analysis of Medicare spending during the 1989-1994 period shows that the costs of new HMO enrollees six months before enrollment were 63 percent of average fee-for-service costs. For beneficiaries who left HMOs, six months afterwards their costs were 160 percent of fee-for-service average costs. These findings were fairly uniform across market areas and types of HMOs.

The second section examines the experience of Medicare beneficiaries while enrolled in an HMO. Relatively little information on costs or service use is available for the period of HMO enrollment, but data on mortality rates and hospital use suggest that new enrollees' costs may rise somewhat once they join an HMO, even after adjusting for aging of the enrolled population. At a minimum, this finding suggests caution in interpreting the very low use of services prior to enrollment as a measure of the average degree of biased selection. It also suggests that risk-adjustment research might eventually consider this "regression toward the mean" in new enrollees' costs as a factor in setting payment rates.

The third section assesses the ability of various risk adjusters to account for new HMO enrollees' low use of services prior to joining an HMO. Two methods based on diagnosis data—diagnostic cost groups

(DCGs) and ambulatory care groups (ACGs)—appear to offer roughly equal improvement over Medicare's current risk-adjustment mechanism. Methods that would pay partly on a fee-for-service basis offer additional improvement and provide a closer match between Medicare payments and individual beneficiaries' costs.

The Commission has devoted considerable attention to the issue of risk selection and alternative approaches to risk adjustment. In its 1994 annual report, the Commission made a series of broad-based recommendations on incorporating risk adjustment and risk sharing into payment policies (PPRC 1994). Prospective risk adjusters should, of course, use routinely available data such as age and sex, though these should also include information on health status or other factors when available. Any risk-adjustment and risk-sharing formulas should be public information, but the actual process of adjustment needs to protect beneficiaries' privacy. In its *Annual Report to Congress 1995*, the Commission recommended competitive bidding as one way to keep Medicare from potentially overpaying plans (PPRC 1995). Even if this were adopted, however, risk adjustment across plans would still play a role in setting payments.

BENEFICIARIES' COSTS BEFORE HMO ENROLLMENT AND AFTER HMO DISENROLLMENT

Most of the evidence on risk selection and Medicare managed-care plans comes from studies of costs that beneficiaries incurred before joining an HMO or after leaving one. The reason for this is clear: information on beneficiaries' health care costs is readily available for these periods, but such cost data are not typically available for beneficiaries while they are enrolled in an HMO.[1]

This section looks at beneficiaries' costs prior to enrollment in an HMO and after disenrollment. The first portion briefly reviews the literature. The second portion examines Medicare data from the period 1989 through 1994.

Experience of Medicare HMO Enrollees and Disenrollees: Highlights from the Literature

Studies of Medicare HMO enrollees have consistently found substantially lower costs prior to enrollment—sometimes up to four years before, even after adjusting for risk factors (Table 15-1). The earliest study of the pre-enrollment experience of Medicare HMO enrollees was done by Eggers (1980). This study compared inpatient spending and services for 984 Medicare beneficiaries who joined the Group Health Cooperative of Puget Sound between 1976 and mid-1979 with that of some 200,000 beneficiaries in a fee-for-service control group. HMO enrollees had about 52 percent to 62 percent fewer services (and 40 percent to 50 percent lower inpatient expenditures) than beneficiaries in the fee-for-service control group.

A subsequent study by Eggers and Prihoda (1982) examined three HMOs participating in the Medicare Capitation Demonstration (Fallon Community Health Plan, Greater Marshfield Community Health Plan, and the Kaiser Permanente Medical Program of Portland). This study looked at pre-enrollment spending

[1] Information available during enrollment is discussed later in the chapter.

Table 15-1. Prior Research on Risk Selection in Medicare HMOs

Authors	Time Period	Sample Size[a]	Study Type[b]	Results
Eggers (1980)	1974-1976	HMO = 984 FFS = 200,000	Prior Use	52%-62% fewer services used by HMO enrollees
Eggers and Prihoda (1982)	1976-1979	HMO = 18,088 FFS = 11,240	Prior Use	20% lower expenditures for HMO enrollees
GAO (1986)	1984	HMO = All enrollees in 27 risk plans	Cross Sectional	23% lower mortality rates for HMO enrollees
Ward (1987)	1985	HMO = 124	Post Disenrollment	Relatively lower health status for disenrollees
Brown (1988)	1980-1984	HMO = 16,886 FFS = 12,524	Prior Use	21% lower expenditures for all HMO enrollees; 54% higher expenditures for disenrollees
Riley et al. (1989)	1980-1986	HMO = 21,177	Cross Sectional	34% lower mortality rates for HMO enrollees in first year after enrollment
Hill and Brown (1990)	1985-1986	HMO = 104,703 FFS = 103,998	Prior Use/ Cross Sectional	23% lower total expenditures, 25% fewer high-cost hospitalizations, and 25% lower mortality mortality rates for HMO enrollees
Kasper, Riley, and McCombs (1991)	1979-1983	HMO = 13,939 FFS = 28,110	Prior Use/ Cross Sectional	24%-42% lower charges in year prior to enrollment and 32%-60% lower mortality rates for HMO enrollees in two years after enrollment
Riley, Lubitz, and Rabey (1991)	1987	HMO = 845,552 FFS >13 million	Cross Sectional	20% lower mortality rates for all enrollees and 23% higher mortality rates for disenrollees
Lichtenstein et al. (1991)	1988	Total = 10,035	Cross Sectional	Favorable health status in 7 plans, neutral health status in 16 plans, no unfavorable health status in any plan
Brown et al. (1993)	1990	HMO = 6,476 FFS = 6,381	Cross Sectional	Predicted HMO expenditures 5.7% lower than predicted payments

SOURCE: Physician Payment Review Commission compilation of previously published studies.

[a] HMO refers to health maintenance organizations.
FFS refers to Medicare's fee-for-service program.

[b] Study type refers to the type of comparison between fee-for-service beneficiaries and HMO enrollees. Prior use studies examine use before HMO enrollment. Cross-sectional studies examine use after enrollment, while post-disenrollment studies examine use after disenrollment.

during the 1976-1979 period for 18,000 aged beneficiaries who joined these plans in 1980 and 1981, compared with spending for 11,000 beneficiaries in a fee-for-service control group. After adjusting for the risk factors used in Medicare payment, the study found that total expenditures were 20 percent lower for HMO enrollees in two of three plans and 4 percent higher in the third plan.[2]

An analysis of the 17 plans in the Medicare Competition Demonstration, which ran from 1982 to 1985, found lower use prior to HMO enrollment (Brown 1988). In the two years before enrollment, risk-adjusted expenditures for HMO enrollees were 21 percent lower than those for fee-for-service beneficiaries.[3] Expenditures for enrollees who eventually disenrolled were estimated to be 54 percent higher than those of the control group during the pre-enrollment period.

A larger study of about 100,000 enrollees in 98 risk plans yielded similar results (Hill and Brown 1990). This study found that average risk-adjusted expenditures in the two years before enrollment (1985-1986) were 23 percent lower for those who joined HMOs compared with the fee-for-service control group, and that the pre-enrollment incidence of hospitalization for high-cost diagnoses was 25 percent lower for enrollees.

For the Medicare population, there have been few comparative studies after disenrollment from HMOs. One study (Ward 1987) found that disenrollees (and enrollees considering whether to leave a plan) in one Medicare HMO tended to be higher users of services and had lower self-reported health and functional ratings compared with continuous enrollees. Studies of the non-Medicare population have also found that, on average, disenrollees had greater expenditures than their fee-for-service counterparts.[4]

Commission Analysis of the 1989-1994 Medicare Experience

The Commission undertook an analysis of HMO enrollees and disenrollees to address a common criticism of the literature—that estimates from the late 1980s are no longer relevant to the recent Medicare HMO enrollment experience. This section reports the first part of the Commission's analysis, which looked at expenditure data to verify two previous findings. First, new HMO enrollees tend to be drawn from fee-for-service beneficiaries with low costs (even after adjusting for the risk factors currently used by Medicare). Second, HMO disenrollees have high subsequent fee-for-service expenditures.

Pre-Enrollment and Post-Disenrollment Expenditures. This Commission's analysis looked at three groups: those who entered an HMO and remained enrolled, those who entered and subsequently disenrolled, and those who were continuously enrolled in fee-for-service Medicare. To belong to either HMO group, the enrollment must have occurred between July 1989 and June 1994. Those who disenrolled must have done so before the end of 1994. Total expenditures were compared across groups. The six-month period prior to enrollment was examined for all HMO enrollees. For those who disenrolled, the six-month

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[2] The third plan, Greater Marshfield, subsequently dropped out of the demonstration.

[3] The estimated differences were 24 percent and 16 percent, respectively, in the two years preceding enrollment.

[4] See, for example, Buchanan and Cretin (1986) and DesHarnais (1985).

post-disenrollment period was also examined. The approach and data are discussed in detail in this chapter's appendix.

The results substantiate the findings of earlier literature. Spending by new HMO enrollees was only 63 percent of that for beneficiaries in the fee-for-service control group in the six months before they joined an HMO (Table 15-2). But this result hides significant differences between those who remained enrolled in the HMO and those who subsequently left. Beneficiaries who stayed had the lowest relative pre-enrollment expenditures of all the HMO enrollee groups, with total spending averaging only about 56 percent of the fee-for-service level.

Table 15-2. Comparison of Total Expenditures and Adjusted Payment Rate, Six Months Before Enrollment among Various Types of HMO Enrollees (ratio of HMO group to fee-for-service group)

Type of HMO Enrollee	Average Total Expenditures	Adjusted Payment Rate
All Enrollees	0.63	1.01
Continuous Enrollees	0.56	0.99
All Disenrollees	1.03	1.08
Enrolled for three or fewer months	1.36	1.14
Enrolled for four or more months	0.87	1.05

SOURCE: Physician Payment Review Commission analysis of 1989-1994 Medicare claims and denominator files, 5 percent sample of beneficiaries.

NOTE: Adjusted payment rate refers to the amount Medicare would have paid for these enrollees if they were fee-for-service beneficiaries.

The post-disenrollment period analysis yielded two general findings. First, on average, beneficiaries who left HMOs experienced higher spending compared with the fee-for-service group. In the six months after disenrollment, expenditures were 60 percent higher than for the fee-for-service group (Table 15-3).

Second, there were significant differences between beneficiaries who left the HMO within three months of enrollment and those who left after a lengthier enrollment. Both groups had high costs after disenrollment, but costs prior to enrollment were quite different. Pre-enrollment spending for long-term enrollees was 87 percent of the fee-for-service levels, but pre-enrollment spending for short-term enrollees was 136 percent of the fee-for-service level.[5] This finding matches survey research showing that short-term and long-term enrollees often have very different reasons for disenrolling from an HMO.[6]

[5] This latter result is consistent with that obtained by Brown (1988).

[6] Survey results indicate that misunderstandings about how HMOs operate, changes in provider or beneficiary location, and market factors account for the majority of disenrollments (Rossiter et al. 1989; Porell et al. 1992). These surveys also suggest that some higher-risk beneficiaries may disenroll either because they perceive they will need additional services or due to their reportedly being encouraged to leave to seek additional services.

Table 15-3. Comparison of Total Expenditures and Adjusted Payment Rate, Six Months After Disenrollment (ratio of HMO group to fee-for-service group)

Type of Disenrollee	Average Total Expenditures	Adjusted Payment Rate
All Disenrollees	1.60	1.13
Enrolled for three or fewer months	1.73	1.18
Enrolled for four or more months	1.54	1.11

SOURCE: Physician Payment Review Commission analysis of 1989-1994 Medicare claims and denominator files, 5 percent sample of beneficiaries.

NOTE: Adjusted payment rate refers to the amount Medicare would have paid for these enrollees if they were fee-for-service beneficiaries.

Variation by HMO Model Type and Market Penetration. Biased selection could plausibly be expected to vary across HMO model types, such as group-model, staff-model, and independent practice association (IPA) HMOs. Traditionally, it has been argued that beneficiaries with heavy service use develop close ties to their physician and are less likely to switch physicians to join a group-model or staff-model HMO. Selection might also be expected to vary by overall market penetration, with higher penetration increasing beneficiaries' perception of HMOs as mainstream care and reducing the extent of selection.

The research literature on Medicare risk contracting provides mixed evidence of variation in biased selection by plan type. The studies of Brown (1988) and Hill and Brown (1990), for example, found that new enrollees in staff-model HMOs had the lowest prior use rates. By contrast, studies by Brown and Hill (1993) and Greenfield and others (1992) found relatively lower utilization rates for enrollees in IPA and group practice prepaid plans compared with those in fee-for-service medicine.

The Commission's analysis of Medicare data shows modest variation in prior use rates across plan types (Table 15-4).[7] Pooling staff-model and group-model HMOs together gives estimates that differ little from those for IPAs, but contrasting group-model and staff-model plans shows a 14-percentage-point lower relative expenditure ratio for group-model plans relative to staff-model plans (Table 15-4). The finding of greater selection for group-model plans may not have much practical significance due to the blurring of distinctions among group-model, staff-model, and IPA plans in the 1990s. For example, matching Medicare's classification to data from InterStudy showed that 35 percent of the plans that Medicare classified as IPAs were classified as other types by InterStudy.

[7] See the technical appendix that follows for the details on how plan type was determined.

Table 15-4. Total Spending for HMO Group Compared with Fee-for-Service Beneficiaries, by Type of Plan and Market Penetration Rate (ratio of HMO group to fee-for-service group)

	All HMO Enrollees	Continuous Enrollees	Plan Disenrollees
Type of Plan			
Staff/group model	0.65	0.54	1.05
Staff model	0.68	0.59	0.98
Group model	0.54	0.41	1.38
Independent practice association	0.61	0.56	1.01
Penetration Rate			
Less than 5 percent	0.69	0.59	1.26
5-9 percent	0.62	0.50	0.93
10-14 percent	0.66	0.61	0.82
15-19 percent	0.66	0.57	1.09
20-24 percent	0.60	0.56	0.98
25 percent or greater	0.62	0.56	1.07

SOURCE: Physician Payment Review Commission analysis of 1989-1994 Medicare claims and denominator files, 5 percent sample of beneficiaries; InterStudy 1994.

Commission analysis found no systematic difference in pre-enrollment expenditures in markets with different Medicare HMO penetration rates (Table 15-4). This appears reasonably consistent with findings in the research literature.[8]

BENEFICIARIES' EXPERIENCE DURING HMO ENROLLMENT

Studies of beneficiaries' use of care before HMO enrollment and after disenrollment have some obvious and significant drawbacks for estimating biased selection. While these studies have the advantage of examining actual data on each beneficiary's use of services, data are available only for limited subsets of the HMO population (new enrollees, new disenrollees) and for a limited time (before enrollment, after disenrollment).

Many researchers have speculated that studies of new HMO enrollees overstate risk selection. Berki and Ashcraft (1980), for example, suggested that risk selection fades as an HMO ages and the influence of each year's new enrollees is reduced. Welch (1985) posited regression toward the mean, the hypothesis that new enrollees' costs would rise over time. Others have suggested that beneficiaries might delay receiving some services until switching plans, resulting in very low utilization just prior to enrollment, referred to as pent-up demand or storage (Luft 1988; Robinson et al. 1993).

[8] Hill and Brown (1990), for example, found very low correlations in relative expenditures across markets with different penetration rates. Subsequent analysis found correlations that were not robust to changes in the statistical specification of the model (Brown et al. 1993). Finally, Riley, Lubitz, and Rabey (1991) found no difference in mortality rates between markets with high penetration rates and the overall average rate.

The Commission's analysis of mortality rates and hospitalization data for HMO enrollees provides some support for Welch's regression toward the mean hypothesis (Welch 1985). Both mortality and hospitalization rates appear to rise somewhat during the beneficiary's first five years of enrollment in Medicare risk-contracting HMOs. This finding does not determine the absolute degree of selection that HMOs experience, nor does it show whether differences in prior use dissipate entirely. It does, however, suggest that low prior use may somewhat overstate the risk selection of the average HMO enrollee.

This section discusses the evidence of Medicare beneficiaries' experience while enrolled in risk-contract HMOs. It begins with a review of previous cross-sectional studies of HMO enrollees, followed by the Commission's analysis of trends in mortality and hospital use by length of HMO enrollment.

Cross-Sectional Studies of HMO Enrollees

The results of cross-sectional cost and mortality rate comparisons have generally shown modest favorable selection into risk-contracting HMOs. Medicare mortality data provide quite a consistent picture of risk selection. Information on health status gives a more mixed view. Relatively few studies provide credible comparisons of costs between HMO and fee-for-service beneficiaries.

Two factors make it difficult to study Medicare beneficiaries once they enroll in an HMO. First, little information is routinely available. Medicare administrative files for HMO enrollees contain mortality data and some limited information on hospitalizations. Occasional surveys or other special studies can provide additional information such as self-reported health status or self-reported utilization of services. Second, service use in an HMO will reflect both risk selection and the HMO's style and efficiency of medical practice. For example, one would expect to see lower hospitalization rates in HMOs even in the absence of risk selection. To analyze HMO cost data, a researcher must specify some technique for separating out the effects of selection from the effects of HMO efficiency.

A wide variety of mortality rate comparisons have uniformly shown lower rates for enrollees even after adjustment for risk factors. An analysis of 27 HMOs found that enrollee mortality rates were 23 percent lower than those of fee-for-service beneficiaries, even after adjusting for risk factors (GAO 1986). Riley and his colleagues (1989) found that lower mortality rates in the year after enrollment were 34 percent lower for enrollees in three HMOs in the Medicare Competition Demonstration compared with rates for their fee-for-service counterparts. By the sixth year after enrollment, however, much of this differential disappeared. Kasper, Riley, and McCombs (1991) found that mortality rates for HMO enrollees in the two years after enrollment were 32 percent to 60 percent lower than those for fee-for-service beneficiaries. A Medicare study examining 1987 mortality data found that HMO enrollees had 20 percent lower mortality rates and that disenrollees had 23 percent higher rates relative to fee-for-service beneficiaries (Riley et al. 1991). Finally, 25 percent lower adjusted mortality rates were found in Hill and Brown's (1990) risk plan study.

Comparisons of health status measures for all HMO members show much more mixed results than studies of mortality rates. Enrollees in only one of the two plans examined by Kasper, Riley, and McCombs (1988) had better health status measures than the fee-for-service control group. For the other plan, there

were no differences between the two groups. A survey of 10,000 HMO enrollees and nonenrollees in the same market during the spring of 1988 found favorable selection in 7 plans, neutral selection in 16 plans, and unfavorable selection in none of the plans (Lichtenstein et al. 1991).[9]

A major evaluation of the early Medicare risk program attempted to measure both costs and risk selection of the cross section of Medicare HMO enrollees (Brown et al. 1993). As part of that project, beneficiaries were surveyed both to obtain self-reported measures of health care use and to identify risk factors such as chronic illness and functional health status. From this, measures of both utilization and selection were imputed. The researchers estimated that HMO enrollees' utilization of services was roughly 20 percent below the fee-for-service average, and that risk selection accounted for only about half of the difference. (They attributed the remaining 10 percentage points to the effects of HMO efficiency.) Their widely cited conclusion was that Medicare was paying plans 5.7 percent more than it would have spent had the enrollees remained in the traditional Medicare program (Brown et al. 1993).[10]

Commission Analysis of Trends in Mortality and Hospital Use by Length of HMO Enrollment

This section analyzes mortality and hospitalization rates for Medicare HMO enrollees. Data on a 5 percent sample of Medicare beneficiaries enrolled in HMOs during the 1989 through mid-1994 period were used to identify the relationship between length of HMO enrollment and rates of mortality and hospital use. Both types of information suggest a systematic increase in enrollees' costs over time, independent of the aging of the enrolled population.

Each beneficiary's length of enrollment in an HMO was counted by cumulating all months of HMO enrollment in any type of HMO.[11] The results were tabulated for the entire cross section of HMO months of data available. Hospitalization and mortality rates were standardized for age and sex, so these results remove the effect of aging per se from the effect of length of enrollment in the HMO.

Mortality data were calculated in a straightforward fashion from Medicare administrative files. Person-months of entitlement and numbers of deaths were tabulated to give age- and sex-adjusted trends in mortality rates by length of enrollment. No sophisticated analysis was needed since mortality data are routinely reported for all beneficiaries, and there was no significant trend in mortality rates over the period studied.

Analysis of Medicare hospitalization data is much more complex because of poor data reporting and marked time trends over the five-year period studied. Under current regulation, the Medicare program

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[9] For the entire U.S. population, studies of health status based on large national surveys have uniformly shown little or no differenee between HMO and non-HMO populations (Choi and Ries 1978; Taylor et al. 1995; Fama et al. 1995). These results are eonsistent with a laek of seleetion but might also suggest that self-reported health status measures are relatively insensitive measures of biased selection.

[10] That is, HMO enrollees would have eost slightly less than 90 pereent of the fee-for-serviee average, while Medieare paid HMOs at 95 pereent of the fee-for-serviee average, leaving an overpayment to plans of 5.7 pereent.

[11] A separate analysis using only eonsecutive months of risk-plan enrollment gave essentially similar results.

should have data available on all hospitalizations for beneficiaries enrolled in HMOs. In practice, these data are often missing. Before 1988, Medicare risk-contracting HMOs had to submit claims-like data (i.e., no-pay bills) for each beneficiary who was hospitalized. Audits of HMO records and Medicare claims files showed that no-pay bills were reported for less than 40 percent of hospitalizations (GAO 1991). In mid-1988, the responsibility for reporting no-pay bills was transferred to hospitals. While reporting rates are significantly higher, no-pay bills are still missing for a large fraction of hospitalizations, and the rate of reporting varies widely across plans and geographic areas (GAO 1991).[12]

While the highly variable data reporting rules out comparisons of hospitalization rates across plans and over time, it does not prevent examining variations in hospitalization by length of enrollment within each plan. Simple adjustments were used to remove all variation in hospitalization rates across both plans and years. First, plans that reported trivial or no data were dropped. Next, each plan-year of data was adjusted to show the same rate of hospitalization.[13] After removing these differences, the data were adjusted for age and sex, and hospitalization rates were calculated by pooling these within-plan-year rates across all observations in the data set.

Results show that death rates and hospital use rise somewhat over the length of the enrollment period studied (Figure 15-1). Mortality rates are lowest during the first six months of enrollment and climb afterward.[14] Part A service use is somewhat high during the first six months, then drops during the second six months but rises thereafter. The initially higher rates of Part A service use could reflect either beneficiaries' pent-up demand for care, or the high use of beneficiaries who tend to disenroll rapidly from HMOs—as reported earlier in the chapter.

Several caveats should be kept in mind when interpreting these results. First, the hospitalization data should be regarded with caution. Poor data reporting required a significant adjustment: all variation in hospitalization rates across plans was removed, so that the analysis looked only at typical variation in hospitalizations across different cohorts of beneficiaries within each plan. Even with this adjustment, the accuracy of the analysis depends on the assumption that, within each plan, hospitalization data are missing uniformly across enrollment cohorts. Second, neither hospitalizations nor death-related costs capture all spending. Patterns of total service use may or may not follow the same trend shown by mortality and hospitalization rates, and trends within HMOs may differ from corresponding trends under fee-for-service Medicare.

Despite these caveats, the increase in mortality rates and hospital use by length of enrollment suggests some regression toward the mean in beneficiaries' costs once they enroll in HMOs. The similarity of the two trends, and the significant proportion of costs accounted for by hospitalizations and deaths, both strengthen the conclusion that total costs follow a similar time trend after enrollment.

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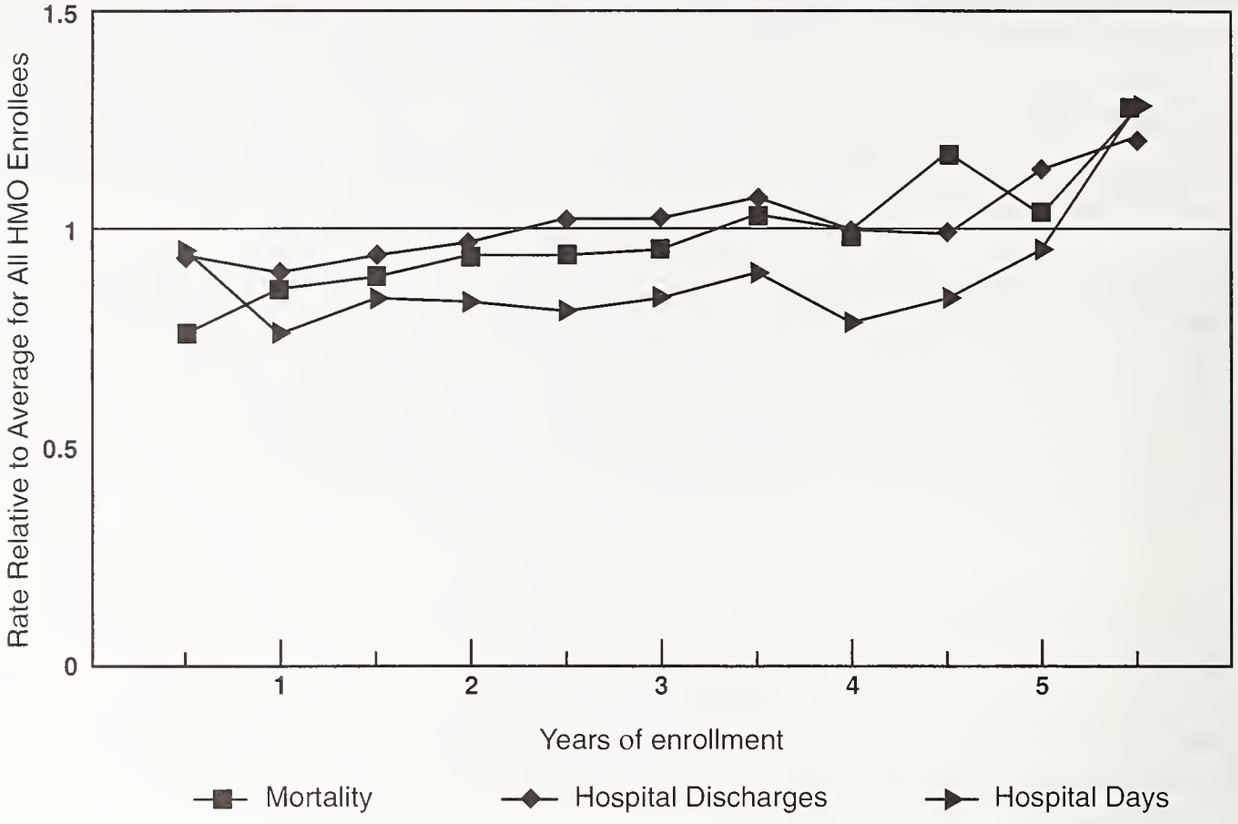
[12] The General Accounting Office noted that neither hospitals nor the fiscal intermediaries have a financial interest in reporting these data accurately (GAO 1991).

[13] For example, if a plan reported half the average number of hospitalizations, each one was multiplied by 2; if a plan reported twice the average level, each hospitalization was multiplied by 0.5.

[14] The overall increase in mortality rates is similar to that observed by Riley and his colleagues (1989).

Figure 15-1. Mortality and Hospital Use Rates by Length of Enrollment



SOURCE: Physician Payment Review Commission analysis of 1989-1994 Medicare claims and denominator files, 5 percent sample of beneficiaries

NOTE: Rates are age and sex adjusted.

These results do not, however, answer the questions of whether or at what point costs reach the fee-for-service level, or how uniformly costs increase across different subgroups of beneficiaries. For example, research by the Health Care Financing Administration (HCFA) has demonstrated that groups defined by permanent characteristics (such as disability) never regress toward the mean, while groups defined solely by a low level of utilization during a base year regress steadily toward the mean over the course of several years (Beebe 1985). Whether HMO enrollees' costs regress fully to the fee-for-service mean or not is an empirical question that must be resolved by looking more closely at the group of beneficiaries actually joining an HMO.

The finding that mortality and hospitalization rates are lower during initial years of enrollment may have implications for studying HMO costs and Medicare payments. As of December 1994, between two-thirds and three-quarters of all beneficiaries in risk-contracting HMOs had been enrolled for fewer than five years, and roughly half had been enrolled for fewer than three years (Table 15-5). These proportions will be higher in HMOs experiencing rapid growth, and lower in those with a more stable membership. Even where total enrollment is steady, however, a significant percentage of all HMO members will be new enrollees as beneficiaries who die or disenroll are replaced by new members. To the extent that average costs per beneficiary differ by length of enrollment, an HMO's costs should also vary according to the average tenure of its enrollees.

Table 15-5. Length of Enrollment for All Medicare Beneficiaries in HMOs (percentage)

Length of Enrollment	Percentage of All Enrollees	
	Continuous Risk Enrollment	Continuous Risk or Cost Enrollment
12 Months or Fewer	27%	21%
24 Months or Fewer	45	37
36 Months or Fewer	57	49
48 Months or Fewer	67	59
60 Months or Fewer	75	66

SOURCE: Physician Payment Review Commission analysis of Medicare denominator file, December 1994.

For three reasons, this regression toward the mean might bear further investigation in the context of risk adjustment. First, low costs prior to enrollment occurred across all market areas and plan types studied. Second, risk rating by length of enrollment is a standard actuarial technique for some types of insurance, and might be useful to Medicare.[15] Finally and importantly, Medicare administrative data include enough information to calculate length of HMO enrollment. If agreement could be reached on an appropriate calibration of a risk adjuster based on length of enrollment, its implementation would not place an additional data-reporting burden on HMOs.

PERFORMANCE OF RISK-ADJUSTMENT AND RISK-SHARING METHODS

The goal of risk adjustment is to project what Medicare would have spent on HMO enrollees had they remained in the traditional fee-for-service program. Good choices for risk adjusters are factors that affect beneficiaries' costs but that are relatively unaffected by actual enrollment in an HMO. Chronic and unavoidable illnesses, for example, are generally regarded as good candidates for risk adjusters.

The goal of risk-sharing approaches is somewhat different. Risk-sharing approaches explicitly try to pay HMOs partly on the basis of actual service use during HMO enrollment. These approaches can be structured either to cover only a small subset of health care costs (say, reinsurance for catastrophic costs or costs related to specific diseases) or a portion of all costs through a blend of capitation and fee-for-service payment.

The performance of risk adjustment or risk sharing can be judged by how well it accounts for variation in costs either across individuals or across groups enrolled in different health plans. These two approaches to measuring risk-adjuster performance differ in their underlying philosophy and operational characteristics. Predictive accuracy at the individual level is important when considering plans' willingness and ability to select enrollees, or alternatively, if policymakers are concerned with protecting access to care for

[15] This technique is standard for insurance that requires an explicit health screening. For example, life insurance that requires a physical examination prior to issuance is often analyzed using the "select and ultimate mortality" or "durational rating" technique. Based on historical data, actuaries would expect to spend more on 41-year-olds who purchased insurance at age 30 than they would for 41-year-olds who purchased insurance at age 40. The "select and ultimate" rate approach is being investigated as part of an ongoing HCFA-funded research project (Actuarial Methods for Improving HCFA Payments to Risk HMOs).

beneficiaries with high expected health care costs (Newhouse 1989). Risk-adjustment formulas that do not capture all the predictable variation in costs will at best leave plans financially unable to attend to the needs of high-cost populations, and at worst provide motivation and opportunity for actively selecting good risks.

Predictive accuracy at the group level is more closely related to the average financial risk that plans and Medicare face. Much of the individual-level variation in costs averages out at the group level, so that plans' typical percentage gains and losses from selection are much smaller than would be implied by variation in costs at the individual level.

In theory, these two approaches could result in widely divergent rankings of risk-adjustment and risk-sharing performance. In practice, however, the performance rankings are roughly similar. For convenience, risk adjustment and risk sharing are discussed in terms of their group-level accuracy, expressed by the degree to which any method successfully explains the low prior health care use of new HMO enrollees.

The remainder of this section compares the ability of several risk-adjustment and risk-sharing methods to explain variations in costs. Explanatory power is examined both for individual beneficiaries' health care costs, and for the costs of the self-selected group of new HMO enrollees. Results of this analysis show that several different techniques being considered by Medicare would offer roughly similar improvements over Medicare's current risk-adjustment mechanism. In addition, risk-sharing methods would move payments closer to costs at the individual level.

Brief Review of the Literature

Risk adjusters can be broadly classified into two types: demographics and health status. Demographic information such as age and gender generally forms the backbone of most risk-adjustment models. Medicare's risk-adjustment method relies exclusively on demographic data, including age, sex, Medicaid buy-in, and institutional status.[16] Health status measures include self-reported health status, functional measures such as difficulty in performing activities of daily living (ADLs), or diagnosis-based measures such as DCGs or ACGs that identify chronic conditions affecting health care costs.[17] Health status measures are typically much harder to obtain than demographics, requiring either surveys or detailed claims data.

The literature shows that prospective risk adjusters explain little of the variation in individual-level health care costs. Age and sex alone capture between 1 percent and 2 percent of cost variation (Lubitz et al. 1985;

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[16] Medicaid buy-in refers to instances where a state Medicaid program pays the Medicare premiums and cost sharing for members of a specified buy-in group.

[17] DCGs and ACGs are risk adjusters that have been developed under contract to the Health Care Financing Administration. Both approaches use diagnosis data to categorize beneficiaries, then use these diagnosis-determined categories to predict costs. The original implementation of these two approaches was quite different, with DCGs focusing on diagnoses found on hospital inpatient claims and ACGs focusing on ambulatory claims; the most recent implementation of these approaches pools all sources of diagnosis information.

Newhouse et al. 1989). The addition of simple health status measures would raise this share to somewhere between 4.5 percent and 6 percent (Newhouse et al. 1989; Hornbrook and Goodman 1994). Measures of prior health care use or specific disease conditions, by contrast, can account for 5 percent to 7 percent of cost variation (Ash et al. 1989; Thomas and Lichtenstein 1986). When a number of different predictors are combined, between 9 percent and 13 percent of cost variation can be explained (Newhouse et al. 1989; Schauffler et al. 1992).

Researchers have argued that the low predictive ability of these risk adjusters leaves incentives for "cream skimming," or selecting the healthiest people (Newhouse 1994). In theory, a perfect risk-adjustment formula might explain as much as 25 percent of the variation in individuals' costs (Newhouse 1996). The relatively poor performance of risk-adjustment formulas leaves much predictable variation in costs that might be used by plans to select enrollees.

There is much less information available on the performance of risk adjusters at the group level. Some research has created artificial groups of individuals drawn from the data by the researcher. Analysis of groups of randomly chosen individuals demonstrates the law of large numbers, namely, that it is easier to predict average health costs for a group than for an individual, with predictability increasing as group size grows (Hayes 1991; Robinson et al. 1991). Other researchers have constructed groups based on specific diagnoses and procedures, such as cancer or heart conditions, and have evaluated the ability of different risk adjusters to predict expenditures for these groups (Anderson et al. 1990). These studies have not, however, examined naturally self-selected groups of individuals, and the accuracy of these adjusters in predicting costs for actual self-selected groups is unknown.

The Commission in September 1993 funded a study to assess alternative risk adjusters—especially those measuring health status—including both self-reported measures of health status—and chronic health conditions, and claims-based measures of morbidity.[18] This project concluded that, in tests of predictive accuracy, claims-based and self-reported measures of health status fare about equally well as individual-level and group-level risk adjusters. From an administrative standpoint, both types of measures have strengths and weaknesses. Claims-based measures of health status depend heavily on the availability of data systems that include an adequate history of diagnosis codes. Survey-based measures incur the costs of surveying plan participants, but can be collected where there are no claims-based data.

Commission Analysis of Risk Adjustment and Risk Sharing

The source of data and initial sampling frame used in this analysis are identical to those used in the previous two sections of this chapter. For this analysis, however, another requirement was the availability of prior service use data for the two years before a beneficiary enrolled in an HMO. With these data, costs in the year immediately preceding enrollment could be predicted based on risk factors present in the year

[18] Detail on the methods and databases used for this project, as well as complete results, can be found in *A Comparison of Alternative Approaches to Risk Measurement* (Park Nicollet 1994).

before that. Because of this requirement, the HMO enrollee sample size fell from 47,575 to 31,477 beneficiaries.

The fee-for-service sample was drawn from a 0.1 percent sample of beneficiaries living in metropolitan statistical areas (MSAs) that had Medicare HMO risk contracts. This approximately matches the geographic distribution of beneficiaries in both the fee-for-service sample and the HMO samples.

The groups had to be matched in terms of death-related costs. Looking back prior to HMO enrollment, there were no such costs (since beneficiaries obviously were living when they enrolled). To get a comparable fee-for-service sample, then, mortality-related costs had to be removed. (See the technical appendix for the statistical methods used.)

To examine risk-adjustment methods, the average payment for new HMO enrollees was based on their predicted costs. Ordinary least squares regression was used to make the prediction. For all beneficiaries, total costs in the year before enrollment were predicted on the basis of risk factors in the previous year.[19] For example, total costs in the year before enrollment were predicted based on age, sex, and Medicaid status two years before enrollment.[20] The regression yields a predicted second-year expenditure for each individual. Averaging these for HMO enrollees and the fee-for-service comparison group gives average expected costs for the groups (Table 15-6).[21]

For risk-sharing methods, payment was divided into the capitation pool and the risk pool. For example, with complete reinsurance above a $10,000 threshold, all payments below that threshold are in the capitation pool, and everything above the threshold goes into the risk pool. The projected payment rate for new HMO enrollees is a combination of average fee-for-service experience in the capitation pool, plus actual new HMO enrollee experience inside the risk pool. Only data from each person's second year are used.[22]

To establish how payments would change relative to the current system, analysis also included risk factors used by Medicare to calculate its adjusted payment rate (APR). The APR is the actual payment rate that a plan would receive, based on the demographic characteristics of its enrollees.

The service use of the new HMO enrollees for the year before enrollment was 29 percent lower than the actual costs of the fee-for-service comparison group (Table 15-6). Adjusting for residual differences in

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[19] For new HMO enrollees, the second year is the year immediately before enrollment, and the first year is the year before that.

[20] In addition, residual differences between the HMO and fee-for-service groups in terms of location and enrollment period were removed using a statistical technique called fixed effects.

[21] The 95 percent factor used in the current payment formula is not included in these calculations. The calculations show the pure effect of the risk-adjustment process.

[22] There is no risk adjustment to the payment for services outside the risk pool—new HMO enrollees simply get the fee-for-service average. Clearly, risk sharing could be combined with risk adjustment of the payment for services outside the risk pool.

Table 15-6. Differences in Prior Use of Health Services Between Newly Enrolled HMO Beneficiaries and Fee-for-Service Beneficiaries

Model	Ratio of Costs to Payment for Prior Use by New HMO Enrollees	Amount of Variation Explained (R^2)	Average Prediction Error*
Unadjusted Means	0.71	---	---
Risk-Adjustment Models			
Model 1: Geographic area and time period	0.77	0.7	7,600
Model 2: Model 1 and adjusted payment rate risk factors	0.80	1.5	7,600
Model 2 and diagnostic cost groups	0.87	7.4	7,400
Model 2 and ambulatory care groups	0.87	6.8	7,400
Prior-Use Models			
Model 2 and prior use	0.84	7.6	7,300
Model 2 and prior use and diagnostic cost groups	0.87	9.9	7,300
Model 2 and prior use and ambulatory care groups	0.88	9.6	7,300
Risk-Sharing Models			
Partial Capitation (50 percent)	0.90	---	3,600
Reinsurance			
$10,000 threshold	0.82	---	3,900
$25,000 threshold	0.75	---	6,100
$50,000 threshold	0.72	---	7,200

SOURCE: Physician Payment Review Commission analysis of 1988-1994 Medicare claims and denominator files, 5 percent sample of beneficiaries.

* Defined as root mean squared error.

geographic location and time period would reduce the gap to 23 percent. Adjusting for differences in the APR risk factors and adding information on DCGs would reduce the gap to 13 percent.[24] Finally, adding ACGs to the APR risk factors would also reduce the gap to 13 percent.

As might be expected, methods based on risk sharing can result in a smaller gap, because they account for actual use during the year. A partial capitation model based 50 percent on risk-adjusted average fee-for-service costs and 50 percent on APR-risk-factor-adjusted prior use of new HMO enrollees would result in a gap of 10 percent (Table 15-6).

Reinsurance can reduce the gap further, but only when a considerable portion of dollars is in the reinsurance pool (Tables 15-6, 15-7). The calculation shown here models complete reinsurance above a threshold. For each beneficiary, all costs below the threshold are paid for out of the capitation payment; all costs above it are paid for on a fee-for-service basis. The estimated HMO payment consists of two parts.

[24] This analysis included variables based on the diagnosis clusters used in DCGs, but there are significant differences between this analysis and DCGs proper. DCGs proper assign only one group to any person (Ash et al. 1989). This analysis included all available diagnosis data and assigned multiple groups to any one person.

For services outside the reinsurance pool, the new HMO enrollee group would be paid at the fee-for-service average. For services inside the reinsurance pool, payment would equal actual costs for the new HMO enrollee group.

As might be expected, for this approach to match the performance of the partial capitation model, roughly half of all costs would have to be included in the reinsurance pool. With a $10,000 threshold per person, 34 percent of all fee-for-service costs are in the reinsurance pool, 6 percent of fee-for-service beneficiaries exceed the reinsurance threshold, and the gap between payments for the new HMO enrollee group and their costs would be 18 percent. A $50,000 threshold would capture 2 percent of costs, less than 0.5 percent of beneficiaries, and leave a 28 percent gap between payments on behalf of new enrollees and their costs (Table 15-7).

Table 15-7. Effects of Complete Reinsurance at Various Thresholds

Threshold	Percentage of Fee-for-Service Spending Above Threshold	Percentage of Fee-for-Service Beneficiaries with Spending Above Threshold	Ratio of Costs to Payment for Prior Use by New HMO Enrollees
$ 5,000	52%	12%	0.88
10,000	34	6	0.82
15,000	23	3	0.79
20,000	15	2	0.76
25,000	11	1	0.75
30,000	8	1	0.74
35,000	5	1	0.73
40,000	4	0	0.73
45,000	3	0	0.72
50,000	2	0	0.72

SOURCE: Physician Payment Review Commission analysis of 1988-1994 Medicare claims and denominator files, 5 percent sample of beneficiaries.

This analysis examined the pre-enrollment costs of new HMO enrollees, which had the advantage of looking at an actual self-selected group of beneficiaries. But four important caveats should be kept in mind when interpreting these results as showing how well a risk-adjustment or risk-sharing method would perform. First, as noted in the previous section, the low use of new enrollees probably overstates the risk selection of the average HMO enrollee. Second, enrollment patterns and risk selection might change once risk adjustment was initiated. Third, in looking only at new enrollees, this approach ignores the potential for selection through disenrollment. Finally, because the group of new HMO enrollees reflects no data on death costs (and correspondingly, death costs have been removed from the fee-for-service comparison group), the data contain too few catastrophic cases. Because risk-sharing methods do better at paying for these catastrophic cases, the analysis may understate the accuracy of risk-sharing methods relative to risk-adjustment methods.

CONCLUSIONS, POLICY DISCUSSION, AND WORK PLAN

The Medicare program has many rules that reduce the potential for biased selection. Managed-care plans must accept all beneficiaries who want to enroll and cannot deny coverage for preexisting health conditions. Plans' marketing materials must be approved by Medicare.

Even so, significant potential for biased selection remains. Numerous published studies have shown that beneficiaries who joined HMOs in the 1980s tended to have below-average costs in the period prior to enrollment. This chapter demonstrates that this is still true in the 1990s. New HMO enrollees had pre-enrollment costs that were significantly lower than the fee-for-service average. Beneficiaries who disenroll from HMOs, by contrast, tend to have very high costs. Any interpretation of these results must be tempered, however, by the finding of a significant rise in hospitalization and mortality rates as length of HMO enrollment increases. Neither new HMO enrollees nor new disenrollees are typical of the average HMO enrollee.

Any proposed improvements in the Medicare's risk-adjustment methods must recognize the critical importance of data. Most approaches would require gathering significant amounts of new data from HMOs; indeed, some would necessitate full claims-type information on all services provided by HMOs. Inasmuch as Medicare has had little success in getting even hospital inpatient utilization data for HMO enrollees, the requirement for new data may be a significant barrier to implementation.

Improvements to risk adjustment must also consider potential effects on the behavior of plans, providers, and beneficiaries. Partial capitation and risk sharing would move HMOs away from full capitation toward fee-for-service payment. Some HMO representatives claim that this would reduce incentives for efficiency. Moreover, these plans are not oriented toward providing care on a fee-for-service basis. Other methods of prospective risk adjustment would not directly introduce fee-for-service incentives. But because a large portion of payment would depend directly on reported diagnosis, utilization patterns, or health status information, significant auditing and oversight capabilities might be needed to ensure the comparability of data across plans and between Medicare's HMO and fee-for-service programs. Further, retrospective adjustments based on utilization patterns may create the same incentives to overutilize that exist under fee for service. These dynamic reactions to risk adjustment would be difficult to predict ahead of time and might require periodic recalibration of the risk-adjustment models.

Several approaches examined here would significantly improve risk adjustment. Both ACGs and DCGs enhance predictive power across self-selected groups, while partial capitation would move Medicare payments closer to costs. Data showing trends in costs by length of enrollment might eventually add another dimension to risk adjustment.

Combining these approaches might result in a more complex but more reliable risk-adjustment strategy. Prospective risk adjusters such as ACGs or DCGs could be applied to determine capitation rates. This would capture the systematic and permanent differences in cost. Partial capitation or risk sharing could be applied to blend these risk-adjusted capitation rates with actual service use, allowing payment rates

partially to reflect the unpredictable variation in costs. Eventually, information on length of enrollment might be used to capture transient changes in costs associated with the decision to enroll in an HMO.

Risk selection and risk adjustment are complicated issues that do not lend themselves to a single best solution. By and large, past and current research have demonstrated the typical explanatory power that might be expected from a wide spectrum of risk-adjustment and risk-sharing techniques. No amount of retrospective research can, however, guarantee a smooth transition to new payment rates or predict how plans and providers may react to these new rates. In the coming year, the Commission will continue to develop its analysis of risk adjustment and risk selection, focusing on practical issues related to the implementation of new payment methods.

Technical Appendix: Methods and Data

The central questions addressed by this study were whether HMOs experience favorable selection in the enrollment process and, if so, whether this carries over into disenrollments. Analyses comparing HMO enrollees and fee-for-service beneficiaries were undertaken to address these questions.

UNADJUSTED MEANS COMPARISONS

Comparisons of unadjusted mean total expenditures and APRs were performed for a six-month period prior to HMO enrollment. Three comparison groups were used: (1) those fee-for-service beneficiaries who never entered an HMO during the analysis period; (2) those who entered an HMO, but did not leave; and (3) those who entered an HMO and left before the end of the analysis period.

The group of beneficiaries who left was disaggregated into short-term (three or fewer months enrolled) and long-term (four or more months enrolled) enrollee subgroups to capture behavioral differences among enrollees. Existing survey data have indicated that a significant proportion of HMO entrants either did not realize they had joined an HMO or were unfamiliar with its features. Further, a substantial portion retained their Medigap policies while they were enrolled, suggesting they had a "try-and-see" attitude toward their new arrangement. It was hypothesized, therefore, that expenditure and utilization rates for these types of beneficiaries may differ markedly from those who enroll for other, perhaps longer-term, reasons.

A second set of comparisons covered the post-disenrollment period. Because data were not available for beneficiaries while they were enrolled in an HMO, it was not possible to use the group who stayed for expenditure comparisons. Instead, these comparisons were restricted to the beneficiaries who left and to fee-for-service groups. As with the pre-enrollment comparisons, the post-disenrollment comparison period lasted six months.

Finally, pre-enrollment comparisons were done according to HMO model type and market penetration rates. The primary source of data used to identify the HMO model type was HCFA's *Medicare Prepaid*

Health Plans Monthly Reports. Data from the 1994 InterStudy Plan Survey were used to identify model types in instances where this was not contained in the HCFA reports (InterStudy 1994). Market penetration rates were calculated as the ratio of Medicare HMO enrollees to all Medicare beneficiaries in a given MSA at the start of 1992, the approximate midpoint in the time period covered by the sample.

DATA AND SAMPLE DESIGN

The fee-for-service and HMO enrollee samples were drawn from the Medicare 5 percent beneficiary denominator files for 1989 through mid-1994. Beneficiaries were included in the HMO samples if they had been in Medicare's fee-for-service program for at least one quarter before joining a risk HMO and did not have end stage renal disease (ESRD). Beneficiaries in the group comprising those who left HMOs had to satisfy two additional criteria. First, they had to have had only one enrollment/disenrollment during the period of analysis. Second, they had to have disenrolled before the end of 1994.

In order to keep the analysis data file manageable, the fee-for-service sample was reduced from 5 percent to 0.5 percent. All non-ESRD beneficiaries who resided in MSAs served by Medicare risk-contracting HMOs and had at least one quarter of fee-for-service eligibility were included in this sample.

Including HMO disenrollees in the analysis created a potential source of sampling bias. All beneficiaries needed at least six months of fee-for-service experience to be in one of the samples. To be in the HMO group who disenrolled, however, beneficiaries needed at least one more month of HMO experience prior to reverting to fee for service. Beneficiaries satisfying this additional criterion might on average live longer on average, and hence be healthier than beneficiaries in the other two samples.

A three-step approach was used to correct for this potential source of sampling bias (Hill and Brown 1990). The approach was intended to remove death-related costs equally for those who stayed in HMOs and for the fee-for-service control group. The first step was to calculate the distribution of disenrollment dates. In the second step, a "pseudo" disenrollment date was randomly assigned to each person in the group staying in HMOs and to those in the fee-for-service sample, according to this distribution. Finally, all HMO stayers and fee-for-service sample members who died before their pseudo disenrollment dates were excluded.

The final sample consisted of 7,233 enrollees who left (2,276 short term and 4,957 long term); 40,342 who stayed; and 74,973 fee-for-service beneficiaries. Except for Medicaid buy-in, on average all HMO enrollees and those in traditional Medicare had roughly comparable eligibility and demographic characteristics (Table 15-8). The proportion of all HMO enrollees covered by Medicaid buy-in was about 40 percent lower than for the fee-for-service group.

There were more noticeable differences between the groups of beneficiaries who left and those who stayed (Table 15-8). Those who left tended to be older and female, have Medicaid buy-ins, and be nonwhite. This was especially true for enrollees in the short-term category, where the proportion of those with buy-in status, for example, was about 70 percent higher than for the fee-for-service group and more than 3.5 times that of the group who stayed.

Table 15-8. Characteristics of Medicare Beneficiaries in Sample Used for Risk Selection Analysis

Characteristic	Fee-for-Service Beneficiaries	All HMO Enrollees	Continuous Enrollees	Plan Disenrollees		
				All Disenrollees	Enrolled for Three or Fewer Months	Enrolled for Four or More Months
Sample Size	74,973	47,575	40,342	7,233	2,276	4,957
Mean Age	68.7	68.2	68.1	69.0	69.0	68.7
Percentage:						
Female	58.1%	55.6%	55.1%	58.2%	61.1%	56.9%
Nonwhite	13.7	15.4	14.4	20.7	21.1	20.1
Medicaid Buy-in	7.1	4.2	3.3	9.0	12.1	7.6
Age 65 and Older	89.3	91.9	92.2	90.2	90.2	90.2

SOURCE: Physician Payment Review Commission analysis of 1989-1994 Medicare denominator files, 5 percent sample of beneficiaries.

Expenditure data were obtained from the Medicare 5 percent claims files for 1989 through mid-1994. Data for inpatient, outpatient, physician, home health agency, and skilled nursing facility services were available for 1991 through mid-1994. For 1989 and 1990, however, data were not available for home health agency and skilled nursing facility services. Finally, the unit of observation in the analytical file was at the beneficiary/quarter level.

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Secondary Insurance for Medicare Beneficiaries

Most Medicare beneficiaries have private health insurance in addition to their Medicare coverage. These secondary insurance policies typically cover some of the health care costs that Medicare does not pay, including deductibles and coinsurance, certain items and services not covered by Medicare, and balance bills.

Secondary insurance provides valuable financial protection to Medicare beneficiaries, but also has implications for the Medicare program. By insulating beneficiaries from the costs of the care they use, secondary insurance increases utilization and Medicare's spending. Differences in the rules and requirements for supplemental insurance policies and Medicare risk-contracting plans, and how these rules affect competition and beneficiary choice are other issues that may become increasingly important as Medicare managed care grows.

As Medicare is restructured to broaden beneficiary choice and place more plans at full risk, the issues relevant to secondary insurance will change, and different options may become more (or less) preferable or feasible. The Commission's work this year profiles the secondary insurance market and identifies some significant issues for the Medicare program. No recommendations about secondary insurance are offered.

The chapter begins with a brief description of Medicare beneficiaries' secondary insurance, including the types of insurance available, the extent of coverage provided, and the premiums for each type of coverage. It also provides a brief overview of legislative and regulatory policies that affect supplemental coverage.

This chapter includes:

- *Profiles of secondary insurance types*
- *The effect of supplemental insurance on service use*
- *Implications of differences between rating practices in Medigap and Medicare risk-contracting markets*
- *Options to modify secondary insurance*

The second section identifies the major issues for Medicare. Among these are Medicare's increased costs due to supplemental coverage, the mismatch between rating practices in the supplemental and Medicare risk-contracting markets, and employer practices that obscure cost differences among plans. A current proposal to modify supplemental insurance rating and underwriting standards is also discussed.

Finally, a number of alternative options to modify secondary coverage for Medicare beneficiaries are identified and three broad approaches to changing secondary insurance are considered. First, efforts to modify supplemental insurance in the context of the current Medicare program are described. Next, voluntary options for supplemental insurers to accept partial risk for the costs of covered services are presented. The final section addresses current full-risk programs and briefly describes one potential option, unified insurance, that would require all supplemental insurers to assume full financial risk. The chapter concludes with a brief outline of the Commission's future work plan related to supplemental insurance.

PREVALENCE AND COST OF SECONDARY COVERAGE

Medicare covers about 45 percent of the total health care costs of the elderly (HCFA 1995a).[1] A variety of sources fund the rest. Private sources—including supplemental insurance, out-of-pocket payments, and insurance covering what Medicare does not—pay about 37 percent of these total costs. Medicaid and other public sources cover roughly 18 percent (HCFA 1995c).

In 1992, more than three-quarters of Medicare beneficiaries held some form of private health insurance (Chulis et al. 1995).[2] Beneficiaries normally obtain such coverage either through a former employer or through private purchase of an individual or group insurance policy (usually referred to as Medigap insurance). In 1992, 37 percent of beneficiaries carried only Medigap insurance, 35 percent had only employer-sponsored supplemental coverage, and 7 percent had both types of supplemental coverage (Table 16-1). The estimated average annual premium for Medigap coverage in 1992 was $1,014, while the average beneficiary with employer-sponsored coverage spent $728 on supplemental coverage (Table 16-1).

The percentage of Medicare beneficiaries with supplemental insurance has increased over time. Between 1977 and 1992, the share of over-65 beneficiaries with private insurance rose from 65 percent to 78 percent, while the proportion with employer-sponsored coverage rose from 24 percent to 42 percent (Chulis et al. 1993, 1995).[3]

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[1] Medicare pays 70 percent of the elderly's hospital bills, 61 percent of costs for physicians' services, 15 percent of spending for other personal care services, and less than 2 percent of nursing home costs (HCFA 1995c).

[2] In 1992, Medicaid provided supplemental coverage to an additional 12 percent of Medicare beneficiaries. See Chapter 18 for more information on Medicaid coverage for Medicare beneficiaries.

[3] The availability of employer-sponsored supplemental insurance has begun to decline. Between 1993 and 1995, the number of large employers that provide Medicare-eligible retiree health benefits has declined by 5 percent (Foster Higgins 1996).

Table 16-1. Types of Secondary Insurance for Medicare Beneficiaries and Average Annual Costs, 1992

Type of Coverage	Percentage of Medicare Beneficiaries	Average Annual Premium Cost to the Beneficiary
Private Supplemental (Medigap) Only	36.6%	$1,014
Employer-Sponsored Only	34.5	728
Both Medigap and Employer-Sponsored	7.1	1,369
Total	78.2	-

SOURCE: Chulis et al. 1995.

MEDIGAP INSURANCE

This section describes the federal legislation and regulations that govern Medigap insurance. These laws were designed to simplify insurance coverage decisions for beneficiaries and to provide them with certain protections against fradulent marketing practices.

Regulation of Medigap Insurance

Over the years, problems with the structure, marketing, and performance of Medigap insurance have been identified. The Congress has responded with legislation designed to clarify beneficiary choices, create marketing protections, and set minimum standards for Medigap insurance.

Consumer-Oriented Standards. In 1980, Congress passed the so-called Baucus amendments to the Social Security Act to address some concerns relating to Medigap insurance. Among these issues were wide variation in the loss ratio performance of supplemental plans, sales and marketing abuses, and the sale of numerous and duplicative supplemental policies to Medicare beneficiaries.[4]

The Baucus amendments created a voluntary certification program under which Medigap policies could adopt a series of consumer-oriented standards. These included a minimum benefits package, minimum loss ratio standards of 60 percent for individual and 75 percent for group policies, marketing standards for uniform definitions and terms to be used in the sale and description of Medigap policies, and a 30-day grace period during which a policy could be cancelled and premiums refunded. This legislation also established a six-month limitation on exclusions for preexisting conditions and criminal penalties for insurance agents who misrepresented or knowingly sold duplicative policies to beneficiaries.

Standardized Medigap Plans. To simplify supplemental insurance and make federal standards mandatory, the Congress enacted stricter Medigap provisions in OBRA90. This legislation limited the type

[4] A loss ratio is the ratio of the total amount of money paid out in benefits to the total amount of premiums collected. A low loss ratio indicates poor value because only a small proportion of the premium dollars collected is paid out in benefits.

of Medigap policies that could be offered to no more than 10 standard plans developed by the National Association of Insurance Commissioners (NAIC). Since July 30, 1992, these are the only insurance policies that can be sold to supplement Medicare.[5]

The 10 standard Medigap plans (known as Plans A-J) range in coverage from a basic core benefits package to more comprehensive policies. The basic policy covers coinsurance for Medicare Parts A and B, additional hospital days, and blood, while the more generous plans include additional benefits, such as skilled nursing facility coinsurance, Medicare deductibles, balance bills, coverage for foreign travel emergencies, at-home recovery, prescription drugs, or preventive medical care (Table 16-2). Under OBRA90, states may further limit either the number or type of available Medigap policies, although the core benefits plan (Plan A) must always be offered.

A 1992-1993 survey of insurance carriers revealed that certain Medigap plans seem to be preferred by beneficiaries (Table 16-2). One-third of beneficiaries purchasing Medigap chose Plan F, which covers core benefits plus deductibles, balance billing, foreign travel emergencies, and skilled nursing home coinsurance. About 40 percent selected either Plan C or Plan B, which cover core benefits and at least the Part A deductible. Only 14 percent of Medigap policies sold included coverage for prescription drugs (Fox et al. 1995).

OBRA90 also established other minimum standards for Medigap policies, including raising the minimum loss ratio standard to 65 percent for individual policies and setting stricter prohibitions against the sale of policies that duplicate Medicare or existing health insurance coverage. It also established an initial six-month open enrollment period for beneficiaries who are at least 65 years old and who are enrolling in Part B, during which premiums can be rated only on the basis of age, sex, and ZIP code.[6] In addition, the legislation required that all Medigap policies be guaranteed renewable.[7]

Strengthening Loss Ratio Standards and Clarifying Duplications. Despite the OBRA90 legislation, concerns about the loss ratio performance of Medigap plans persist. The 1993 average loss ratios for individual and group Medigap policies were 75 percent and 85 percent, respectively, according to a 1995 report by the General Accounting Office (GAO). Even so, 38 percent of policies, representing 10 percent of premiums, failed to meet minimum loss ratio requirements (GAO 1995).[8]

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[5] States whose legislatures were not scheduled to meet before the deadline were granted extensions. Montana and Oregon implemented standardization legislation in July 1993 and March 1994, respectively. Three states, Massachusetts, Minnesota, and Wisconsin, have waivers of the standardization requirement.

[6] Outside of this six-month open enrollment period, insurers can rate premiums on any additional criteria (such as disability or smoking status) allowed by individual states.

[7] Employer-, group-, and union-sponsored plans are not subject to these requirements. Plans that were sold before OBRA90 went into effect can still be renewed, although they cannot be offered for sale.

[8] There is some disagreement in the health insurance industry about GAO's use of a single standard to determine the credibility (i.e., the number of persons covered and the annual amount of total premium revenue generated by a policy) of policies and the report's application of group loss ratio standards to policies that might be considered individual under an NAIC model (Gradison 1996a).

Table 16-2. Benefits Covered under Standardized Medigap Policies and Sales Distribution of Different Plans

Covered Benefits	Standardized Medigap Plans									
	A	B	C	D	E	F	G	H	I	J
Core Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
Skilled Nursing Home Care Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery				✓			✓		✓	✓
Part B Deductible			✓			✓				✓
Part B Excess Charges						✓	[a]		✓	✓
Prescription Drugs								[b]	[b]	[c]
Preventive Medical Care					✓					✓
Distribution of Sales[d]	7.0%	16.3%	22.0%	4.4%	1.2%	32.7%	2.3%	6.0%	3.3%	4.8%

SOURCE: National Association of Insurance Commissioners' Model Regulation 1995 and Fox et al. 1995.

[a] Medigap policy pays 80 percent of balance billing charges.

[b] After a $250 deductible, the policy covers 50 percent of prescription drug costs to a limit of $1,250.

[c] After a $250 deductible, the policy covers 50 percent of prescription drug costs to a maximum of $3,000.

[d] This distribution is derived from the results of a 1992-1993 survey of insurance carriers.

NOTE: Core benefits include Part A copayment for days 61-90 in the hospital, Part A copayment for each lifetime reserve day in the hospital, up to 365 additional days of hospital coverage after Medicare coverage is depleted, the first three pints of blood used under Part A or Part B, and the 20 percent coinsurance for Part B services after the Part B deductible has been met.

After a policy's introduction and an initial exemption period, OBRA90 required all standardized Medigap plans to issue refunds or credits to purchasers when and if plans failed to meet minimum loss ratio requirements. As of 1995, states could require all standardized plans to comply with these requirements. The Social Security Act Amendments of 1994 extended minimum loss ratio and credit and refund requirements to all pre-OBRA90 Medicare supplements. These prestandardization plans will be subject to refund and credit requirements beginning in 1998. This legislation also modified certain prohibitions against selling duplicate health insurance policies to allow the sale of policies that contain certain incidental duplications of services with Medicare and other health insurance coverage if certain

requirements are met.[9] In accordance with this law, the NAIC developed a series of disclosure statements that must be displayed on insurance policies, such as hospital indemnity, accident, specific or dread disease, and long-term care policies, that might duplicate a beneficiary's existing Medicare coverage. Policies sold on or after August 11, 1995, must bear these new disclosure statements. Plans sponsored by employers, groups, or unions are not required to disclose potential duplications of coverage to their enrollees.

Enforcing Medigap Regulations

States have the primary responsibility to oversee Medigap policies, but OBRA90 allows for federal review of state enforcement policies (especially as they relate to loss ratio standards). The Secretary of the Department of Health and Human Services (HHS) is authorized to study and evaluate state approaches to regulating Medigap insurance and must report on the effectiveness of federal standards and criminal penalties for violations. State governments retain the right to regulate all other insurance plans for the elderly, subject to federal disclosure requirements. A review by the HHS Office of Inspector General (OIG) found that OBRA90 reforms have "substantially improved state regulation of Medigap insurance," and that many states have adopted standards that exceed OBRA90 requirements (OIG 1995).

EMPLOYER-PROVIDED SECONDARY COVERAGE

Many employers provide health insurance benefits to their Medicare-eligible retirees as part of their company retirement package. When a retired person turns 65 and becomes Medicare-eligible, Medicare becomes the primary payer for all Medicare-covered services.[10] Employer-provided coverage augments Medicare benefits and acts as secondary insurance to Medicare. This insurance is often more generous than Medigap and is typically less costly for the beneficiary. Employer-provided coverage is subject to certain legislative and regulatory requirements, and is generally coordinated to interact with Medicare. In recent years, employer-provided secondary coverage has begun to be modified in response to increasing costs.

Background

The costs for employer-provided secondary coverage are typically divided between employers and beneficiaries. On average, retirees sharing the cost of their health insurance with their employer pay 28 percent of the premium (Jensen and Morrisey 1992). The average beneficiary with employer-sponsored supplemental insurance spent $728 for supplemental coverage in 1992 while, in 1995, the average large employer spent about $1,800 per capita on Medicare-eligible retirees' health benefits (Chulis et al. 1995; Foster Higgins 1996). Experts note that prescription drug coverage typically accounts for close to 40 percent of employers' expenditures on retiree health benefits.

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[9] Insurance that duplicates benefits must meet two conditions. All benefits under the policy must be payable directly to or on behalf of the policyholder, regardless of his or her other health insurance coverage, and the issuer must display disclosure statements notifying potential purchasers of overlaps between the policy in question and the policyholder's existing Medicare coverage.

[10] People who work past the age of 65 continue to be covered by their employer's insurance plan. Medicare acts as the secondary insurer to these beneficiaries for all Medicare-covered services.

These averages obscure the wide variation in premium cost-sharing arrangements between retirees and their former employers. Of companies employing more than 500 workers, 28 percent provide free individual coverage, 28 percent contribute nothing toward coverage, and 44 percent share coverage costs for Medicare-eligible retirees (Foster Higgins 1996).[11]

Most employer-sponsored plans offer similar coverage to their working and retired populations (Jensen and Morrisey 1992). As with active employees' coverage, most retiree health plans require some deductible and coinsurance payments (Clark and Kreps 1989). For example, the median plan in a survey of employer-provided health plans for Medicare-eligible retirees had a $200 deductible and covered 80 percent of charges for covered services above the deductible (GAO 1994).

Employer-provided benefits often provide more extensive coverage than typical Medigap insurance. Most employer-sponsored retiree health plans include coverage for prescription drugs in addition to basic Medicare benefits. About 30 percent of employer-sponsored plans cover vision and dental care. Employer plans also often include catastrophic coverage or limits on out-of-pocket expenses within maximum lifetime-benefit caps (GAO 1994).

Coordination of Coverage with Medicare

Employer-provided health benefits for Medicare-eligible retirees frequently overlap significantly with basic Medicare benefits. In response, employers have adopted five basic approaches to integrating or coordinating their benefits with Medicare's: carve-out coverage, wraparound coverage, coordination of benefits coverage, exclusion coverage, and defined contributions (Table 16-3).

Table 16-3. Prevalence of Coordination Methods Among Large Employers, 1994

Type of Coverage	Percentage of Large Employers
Carve-out	40
Wraparound	21
Coordination of Benefits	18
Exclusion	21

SOURCE: Foster Higgins 1995.

NOTES: Large employers are defined as those with more than 500 employees.

In 1994, 3 percent of large employers reported changing to defined contributions since 1992. These employers are not included in the above distribution.

Foster Higgins' survey did not specifically differentiate or define the type of coordination that a Medicare risk plan would represent, so individual firms defined their arrangements with managed-care plans themselves.

[11] Family coverage displays a slightly different pattern of premium cost sharing. Twenty percent of large employers provide free family coverage, 31 percent require the retiree to pay the full costs of family coverage, and 50 percent share the cost of family coverage with their Medicare-eligible retirees (Foster Higgins 1996).

Carve-Out Coverage. Carve-out plans, the most common form of employer-provided benefits, deduct the amount that Medicare pays for a service from the plan's allowed charge for the same service and pay the difference. The beneficiary is responsible for any balance remaining on the bill as well as for the plan's deductible and coinsurance requirements. Take, for example, the case of a nonparticipating physician who bills a beneficiary $112 for a particular service. The Medicare-allowed charge is $100. The employer-sponsored plan is willing to pay $108 for the service. Medicare pays $95 and, assuming the beneficiary has met the plan's deductible, the employer plan pays $13 for the service ($108 less Medicare's payment). The beneficiary is left with a bill of $4. If the plan had been willing to pay $120 for the service, the beneficiary would have owed nothing.

Wraparound Coverage. Wraparound coverage resembles Medigap insurance in that these plans tend to cover Medicare cost-sharing requirements and additional benefits like prescription drugs, preventive care, and dental care. Such coverage may or may not require cost sharing.

Coordination of Benefits Coverage. Under coordination coverage, the employer-sponsored plan typically pays the difference between actual charges and Medicare's payment up to the amount that the plan would have been willing to pay in the absence of Medicare. Under most coordination of benefit plans, Medicare-covered services are essentially free, while those that Medicare does not cover are subject to the employer-sponsored plan's coinsurance requirements (Clark and Kreps 1989; Morrisey et al. 1990). For example, say a nonparticipating physician bills a beneficiary $112 for a particular service. The Medicare-allowed charge is $100. Assuming the beneficiary has met the plan's deductible, the employer plan is willing to pay up to $108 for the service. Medicare pays $95, leaving the employer plan with a bill of $17, which it covers. The beneficiary pays nothing.

Exclusion Coverage. Under exclusion coverage, Medicare payments are subtracted from actual claims and the employer-sponsored plan's benefits are applied to the balance. Such coverage generally leaves the beneficiary responsible for the employer's plan's cost sharing and deductibles.

Defined Contributions. Under a defined contribution plan, specified monetary payments are made directly to or on behalf of retirees to cover supplemental benefits. This form of coverage essentially leaves the retiree at risk for any premium differentials among individual plans.

Changes in Employer-Sponsored Coverage

Recent changes in accounting requirements, as well as rapidly rising health care costs, are leading many employers to reconsider their retiree health programs. The independent Financial Accounting Standards Board (FASB) enacted a rule (FAS 106), effective in 1992, that requires companies to include the costs of their present (accrued) and anticipated liabilities for retiree health benefits on their annual financial statements. Employers have the option of taking either a one-time charge against earnings for all anticipated retiree health costs or amortizing their liability over a maximum of 20 years (CRS 1993; Monheit and Schur 1989).[12]

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[12] Firms that opt to prefund retiree health benefits currently enjoy no tax benefits for doing so. The money that is set aside to fund future retiree health costs is not generally deductible from income, and the interest income earned on those funds is taxable (CRS 1993). The difficulty that employers have in prefunding their benefits, combined with the FASB requirements that they account for their current and anticipated liabilities for retiree health costs, may contribute to a gradual decline in the number of employers that provide health care coverage for their Medicare-eligible retirees and to an increase in the number of employers providing benefits through predetermined, defined contributions.

From 1994 to 1995, the number of large firms (those with more than 500 employees) offering coverage to their Medicare-eligible retirees dropped from 40 percent to 35 percent (Foster Higgins 1996). Moreover, a substantial number of employers have already altered or anticipate changing retiree health benefits by 1997. Such changes include increasing retiree contributions, increasing cost sharing, adding a freestanding prescription drug benefit, and tightening eligibility requirements. Since 1992, 3 percent of employers also report transitioning to defined contributions (Foster Higgins 1995). Some of these changes parallel modifications made to active employees' health benefits, while others may decrease the parity of health benefits for active and retiree populations.

Many employers are reacting to increased cost pressure by moving their Medicare-eligible retirees into managed-care plans (Towers Perrin 1995). In 1995, 21 percent of employers with more than 500 employees offered at least one Medicare risk-contracting health maintenance organization (HMO) to their Medicare-eligible retirees, up from just 7 percent two years earlier (Foster Higgins 1996). Under the National Medicare HMO Initiative, 60 large firms are seeking to increase the proportion of their 1.5 million Medicare-eligible retirees enrolled in Medicare risk-contracting HMOs.

Moving Medicare-eligible retirees into risk-contracting plans can be beneficial to employers by reducing premium and claims costs and allowing firms to more accurately predict retiree health costs (Towers Perrin 1995). An initiative in Florida to increase retiree membership in Medicare HMOs saved employers anywhere from $500 to $2,000 per year on per capita retiree premium costs (Stover 1995). Retirees may also benefit from participation in Medicare risk-contracting HMOs because of the expanded benefits offered by many of these plans (Towers Perrin 1995).

Regulation of Employer-Sponsored Coverage

Employer-sponsored health benefits for Medicare-eligible retirees vary widely and are typically subject to some generally recognized standards and legislative requirements. For instance, numerous court decisions have limited employers' ability to modify or discontinue health insurance benefits to retirees. The courts have determined that the firm's legal obligation is to provide health benefits as promised, unless the employer has explicitly reserved the right to modify the plan or benefits within plan descriptions (Morrisey et al. 1990). Several federal laws also apply to employer-provided health benefits for Medicare-eligible retirees.

Because numerous employer-provided health plans for Medicare-eligible retirees are self-funded, the rules established in the Employee Retirement Income Security Act of 1974 (ERISA) apply (Morrisey et al. 1990). ERISA, which focused primarily on pension benefits, effectively expanded employers' abilities to self-fund health benefits for both their active and retiree populations. It also allows retirees to sue in state or federal court to enforce their rights, recover their benefits, or clarify their entitlement to future health benefits (CRS 1993).

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, the 1984 Deficit Reduction Act (DEFRA), and the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 established the employer's role as primary payer for Medicare-eligible employees. TEFRA required employers to offer the same primary

health insurance coverage to active 65- to 69-year-old workers as they offer to younger active employees, while DEFRA expanded employers' responsibility as primary payer to include coverage for the health care costs of active workers' Medicare-eligible spouses (Short and Monheit 1988; Monheit and Schur 1989). COBRA expanded these requirements to include all beneficiaries working past age 69 and their spouses.

POLICY ISSUES FOR MEDICARE

There are two major policy issues relating to secondary insurance and Medicare. First, supplemental insurance reduces the beneficiary's cost of service use and thereby raises utilization. This higher utilization is paid for primarily by Medicare. Second, Medicare supplemental and risk-contracting plans currently use different methods to set premiums. These differences raise issues relating to beneficiary choice among competing Medigap and Medicare risk-contracting plans.

Medicare beneficiaries who seek expanded coverage currently have two basic options when they elect their Medicare coverage: traditional Medicare with a Medigap or employer-provided supplemental policy, or a Medicare risk-contracting plan. In a restructured, multiple-choice Medicare system, another broad option—new capitated health plans with or without additional supplemental coverage—would be available. In a competitive Medicare market, a beneficiary's ability to compare numerous options on the basis of costs and coverage will be crucial.

Effect of Supplemental Insurance on Service Use

By making beneficiaries sensitive to their health care expenditures, Medicare's cost-sharing requirements are in part intended to encourage cost-conscious utilization. Insurance policies that supplement Medicare by paying for deductibles and coinsurance remove this incentive and prevent Medicare from using even mild financial incentives (in the form of higher deductibles or variable cost sharing) to steer beneficiaries towards certain providers or types of services. The extent to which such supplemental coverage insulates beneficiaries from costs and serves to increase beneficiaries' expenditures is of concern for the Medicare program.

Research evidence shows that reduced cost sharing in an otherwise unrestricted health plan is associated with increased health services use. Under the RAND Health Insurance Experiment, which randomly assigned nonelderly people to health plans with different cost-sharing requirements, medical expenditures for a fully insured population were 23 percent higher than for those with a 25 percent coinsurance rate (Manning et al. 1987; Newhouse 1993).[13] Numerous other studies of the effects of coinsurance on the Medicare population have produced results similar to the RAND study. In general, beneficiaries with first-dollar coverage (i.e., supplemental policies) have rates of service use that are approximately one-fourth to one-third greater than those for beneficiaries without supplemental coverage (Chulis et al. 1993; McCall et al. 1991; Taylor et al. 1988; Christensen et al. 1987; Link et al. 1980).

[13] Despite these higher expenditures among fully insured individuals, however, net health status among groups did not change except for those who were poor and sick (Newhouse 1993).

The Commission's analysis of data from the 1993 Medicare Current Beneficiary Survey confirms these estimates. Beneficiaries with supplemental coverage (Medigap or employer-provided) cost Medicare roughly 28 percent more than beneficiaries without this coverage (Table 16-4).

Additional service use for fully insured beneficiaries varies by type of service and may be influenced by the urgency of the need for care, Medicare copayment policies, or both. Beneficiaries with supplemental coverage use roughly twice as much preventive care (which by definition does not treat any immediate medical need) as those beneficiaries without this coverage. Similarly, physicians' services (which are used for both actual and suspected illnesses) are used about two-thirds more often among supplementally insured beneficiaries as among Medicare-only beneficiaries. But hospital inpatient utilization, which typically addresses serious or urgent problems, is only slightly higher for those with supplemental insurance than for those without it. Finally, home health care, which requires no

Table 16-4. Measures of Medicare Service Use for Beneficiaries with Different Types of Supplemental Insurance Coverage, 1993

Measure of Service Use	Medicare Only	Supplemental Insurance Coverage: Employer-Provided	Supplemental Insurance Coverage: Individually Purchased
Total Payment	$2,356	$3,027	$3,042
Total Part A Reimbursement	1,618	1,800	1,763
Inpatient reimbursement	1,331	1,560	1,451
Home health reimbursement	247	197	233
Skilled nursing facility reimbursement	38	35	63
Hospice reimbursement	0	11	15
Total Part B Reimbursement	739	1,227	1,279
Physician reimbursement	573	928	971
Outpatient reimbursement	166	295	307
Percentage of Beneficiaries:			
With at least one office visit	61%	86%	88%
Receiving flu shot	30	52	52
Percentage of Female Beneficiaries Receiving:			
Mammogram	18	38	33
Pap smear	15	31	27

SOURCE: Physician Payment Review Commission analysis of data from the 1993 Medicare Current Beneficiary Survey. Sample includes 11,540 beneficiaries with both Part A and Part B coverage who are not enrolled in health maintenance organizations.

NOTE: About 10 percent of Medicare beneficiaries have only Medicare, with no supplemental insurance policy; 32 percent have one or more supplemental insurance policies that they obtained from their employer. Another 31 percent have at least one individually purchased Medigap policy. About 7 percent have both employer-provided and individually purchased policies. For roughly 16 percent of beneficiaries, Medicaid supplements Medicare. The remaining 5 percent have a combination of other supplemental policies. Total does not add to 100 due to rounding.

All totals may not equal the sums of their components due to rounding.

copayments, is actually used more frequently by those who lacked supplemental insurance than by those who had it (Table 16-4).

Some have suggested that the higher costs of those with secondary insurance do not reflect the effects of such insurance per se, but can be accounted for by other factors. One argument is that the purchase of insurance is correlated with many other factors affecting service use, such as income and health status. Higher levels of use might be due to these other factors rather than to insurance. A second argument is that beneficiaries who expect to use more care might be more likely to purchase supplemental insurance. This would make higher service use the cause, not the effect, of supplemental insurance ownership.

Detailed analysis suggests that neither of these arguments accounts for the high service use of beneficiaries with secondary insurance. Instead, the high service use appears to be a direct consequence of the secondary insurance.

The Commission's analyses examined several factors that are correlated with ownership of secondary insurance in detail. These factors included income, health status, race, sex, age, disability status, and urban and rural designations. Examined individually, these factors had no consistent pattern. For example, beneficiaries without supplementary insurance have notably lower self-reported income (which should correlate with lower health care utilization), but also have lower self-reported health status (which should result in higher utilization rates). Taken together, accounting for these factors in a multivariate model (not shown) had little impact on the estimated effect of supplemental insurance. Including these variables in the analysis resulted in somewhat larger estimated differences in total spending between those with and without supplemental coverage, but narrower differences in preventive care use. Qualitatively, the results were the same as those depicted by the unadjusted data.

A number of independent factors suggest that higher use of services is the consequence of and not the cause of secondary insurance ownership. First, analysis of CBS data shows that beneficiaries without supplemental insurance are in poorer health compared to those with supplemental policies. That runs contrary to the assertion that the need for coverage is the primary determinant of ownership of secondary insurance. Second, the increase in service use shown here is roughly the same size as was found in the RAND Health Insurance Experiment, in which individuals were randomly assigned to plans with different levels of coverage. Because the RAND experiment was a randomized, controlled trial, those results unquestionably show the effect of insurance on service use and not the effect of high expected use on the purchase of insurance. Finally, in the preceeding analysis of utilization among different service types, differences in utilization were not uniformly higher across the board (as one would expect if need for care were the only factor driving service use), but instead appeared to reflect varying price sensitivity.

Implications for Medicare. Higher utilization among Medicare beneficiaries with Medigap insurance translates directly into increased Medicare program costs because Medicare is the primary payer for these services. If the typical increase in care related to full secondary insurance is 25 percent, this adds roughly $1,000 per fully insured beneficiary to Medicare's costs.

Some of the increased utilization due to supplemental insurance may, however, be appropriate and medically necessary. The level of use among Medicare-only beneficiaries is not necessarily optimal. The

Commission's analysis shows that beneficiaries with no supplemental insurance had the lowest use of preventive care. To the extent that preventive care is considered beneficial, higher rates of cost sharing could have detrimental effects on quality of care.

Currently, the Medicare program, not the supplemental insurer, bears the majority of the costs of higher utilization among beneficiaries with supplemental insurance. As Medicare is restructured to offer beneficiaries more choice, the new capitated managed-care plans will face similar risks. To the extent that beneficiaries are able to purchase supplemental coverage to augment plan benefits, new Medicare plans will face the risk of increased costs.

The new Medicare plans most likely to be affected by first-dollar coverage would be fee-for-service and point-of-service plans whose cost-sharing requirements might differ based on the provider used. In order for the financial incentives of medical savings accounts (MSAs) to remain intact, supplemental coverage of the MSA deductible should be prohibited.[14]

Rating Practices

Medigap insurers and Medicare risk-contracting plans operate under different rules with respect to premium rate setting and underwriting. These differences raise two important issues: the appropriateness of applying different standards to the two types of insurance coverage, and the implications these different pricing strategies have for beneficiary access to supplemental coverage and beneficiary choice between Medicare fee-for-service and Medicare managed care.

Rating Practices for Medigap Policies. Three types of rating are used to set the prices for Medicare supplemental insurance products: community rating (generally with separate rates for the aged and disabled populations), rates based on the beneficiary's age when the policy is issued, and rates based on the beneficiary's attained age.[15] Among these, age-attained rating is growing fastest (*Consumer Reports* 1994; Fox 1995). Although Medigap insurers are prevented from refusing coverage to applicants during a beneficiary's initial six months of Part B enrollment after turning 65, insurers may refuse coverage to individuals on the basis of their health status after that open enrollment period. Depending on state laws, they may also impose six-month preexisting condition exclusions on insurance they do issue to the extent that the benefits covered by the supplemental plan are new.[16]

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[14] The congressional conference agreement (H.R. 2491) included provisions to ban supplemental coverage of MSA deductibles.

[15] Community rating results in all beneficiaries paying the same price for the same coverage. The cost for community and age-at-issuance rated policies rise only with inflation and cost experience, while age-attained rated premiums rise with inflation and cost experience as well as with age.

[16] Depending on the state, Medigap insurers can impose six-month preexisting condition exclusions on a policywide basis during the initial six-month open enrollment period. They cannot, however, impose exclusions on individual beneficiaries during that period. Continuously insured beneficiaries who have satisfied the six-month waiting period under one Medigap policy are subject only to six-month preexisting condition exclusions for new benefits obtained under a new Medigap policy to the extent allowed by the state.

The use of these different rating practices may complicate premium comparisons among Medigap policies. Critics suggest that without full disclosure of rating practices, attained-age rating may entice young beneficiaries to purchase Medigap policies that appear less expensive than community-rated or age-at-issuance rated policies, when in fact, over the policyholder's life, they may be much more expensive. This could occur because age-attained premiums rise significantly as the beneficiary ages.[17] Supporters of age-attained rating contend that age-attained rates result in rates that more accurately reflect the costs of an individual beneficiary's supplemental coverage and provide beneficiaries with valuable choice (Gradison 1996b).

Medigap rating practices may also encourage some beneficiaries to purchase duplicative supplemental coverage.[18] For example, those concerned that their retiree benefits might be reduced or eliminated in the future might be induced to purchase Medigap insurance during their initial open-enrollment period to ensure its availability to them in the future (GAO 1994).

Rating Practices for Medicare Risk-Contracting Plans. Medicare risk-contracting plans often provide supplemental benefits. These may be offered at no cost to the beneficiary (in cases where Medicare's payment to the plan exceeds the cost of providing basic Medicare benefits) or plans may charge an additional premium. When there is an additional premium, however, the plan must charge a uniform premium and accept all enrollees, regardless of health status.

Implications of Different Rating Practices. The implications of different benefits, as well as underwriting and pricing policies, differ for beneficiaries, plans, and the Medicare program. From the beneficiary perspective, different standards can make well-informed choices among various options difficult. For example, in order for a beneficiary to choose between traditional fee-for-service Medicare plus a supplemental policy and a Medicare risk-contracting plan, the beneficiary must be able to weigh differences in prices and benefits. The artificial barriers to choice raised by these different practices will become even more critical if beneficiaries must choose among traditional fee-for-service Medicare and supplemental coverage, enrollment in a Medicare risk-contracting plan, or enrollment in a new Medicare plan plus supplemental coverage.

Differences in rating and underwriting practices may also result in beneficiaries purchasing or retaining Medigap insurance that they do not need. For example, differential rating practices may inhibit beneficiaries' ability to switch among Medicare risk-contracting plans and traditional Medicare by imposing financial costs in the form of potentially increased Medigap premiums or preexisting condition exclusions.[19] To avoid such costs, beneficiaries enrolling in risk-contracting plans may retain their Medigap policies to ensure their availability should they return to traditional Medicare.

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[17] Ten states prohibit the use of age-attained rating for Medicare supplemental insurance products: Arkansas, Connecticut, Florida, Georgia, Idaho, Maine, Massachusetts, Minnesota, New York, and Washington.

[18] Prohibitions against the sale of duplicative coverage require insurance agents to notify beneficiaries of possible duplications of benefits and to obtain the beneficiary's signature of intent to cancel other duplicative policies. The onus to cancel redundant coverage, however, is on the beneficiary. If the beneficiary fails to cancel duplicative policies, there is no penalty on either the insurance agent or the beneficiary.

[19] To the extent that guaranteed issue, community-rated Medigap policies remain available, this may not be an issue for Medigap plans that do not include prescription drug coverage (i.e., Plans A-G in Table 16-2).

Stricter rating and underwriting policies may place risk-contracting plans at a competitive disadvantage. After a beneficiary's initial six-month open enrollment period, for example, insurers offering Medigap policies that include a prescription drug benefit are able to refuse coverage to beneficiaries with high anticipated prescription costs. By contrast, risk-contracting plans that provide prescription drug benefits must offer that coverage to all Medicare enrollees. This may create an incentive for beneficiaries with specific health needs or low incomes to enter managed-care plans. In fact, on average, Medicare risk-plan enrollees have lower incomes than those in fee-for-service Medicare and are less likely to have had supplemental coverage prior to their enrollment in a risk-contracting HMO (Brown et al. 1993).

Alternatively, uneven rating and underwriting practices among supplemental and Medicare-risk insurers could cause adverse selection into traditional Medicare. This could occur if sick beneficiaries opted to remain in fee-for-service Medicare rather than risk losing or having difficulty reacquiring Medigap coverage if they joined a managed-care plan and later disenrolled.[20] In either case, the uneven alignment in incentives among Medigap and risk-contracting plans may mean that Medicare is not benefiting from competition among the choices available to Medicare beneficiaries.

Proposed Reforms. The Administration has proposed two policies to address the uneven rating practices in the Medicare supplemental market: community rating of supplemental premiums and guaranteed issue for Medigap insurance.[21] Although these policies were proposed in the Administration's legislation to restructure Medicare, either could be enacted in the context of the current system. Guaranteed-issue community-rated Medigap policies would eliminate the current disparity between Medigap and Medicare risk-contracting rating practices, and enable beneficiaries to make more accurate price comparisons among various coverage options.

Insurers are concerned, however, that open enrollment and community rating would have negative consequences, specifically, adverse selection into and among supplemental plans and higher premiums for Medigap coverage. In addition, they argue that removing medical underwriting and preexisting condition exclusions would make it easier for sick beneficiaries to disenroll from risk-contracting plans and reenter traditional Medicare, potentially increasing Medicare costs.

Employer-Sponsored Coverage

Another issue that will become more critical if Medicare is restructured is the effect of employer-provided supplemental coverage on beneficiary choice and access to various plans. When employers contribute to the costs of supplemental insurance for their Medicare-eligible retirees, they can obscure the true premium and cost-sharing differentials between plans. For example, when employers cover Medicare cost sharing plus supplemental benefits in the fee-for-service program, beneficiaries are shielded from the price difference between traditional Medicare and Medicare managed-care plans.

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[20] Although this a fear among many beneficiaries, to the extent that insurers continue to voluntarily offer guaranteed-issue, community-rated Medigap policies, it may not be fully justified.

[21] Congressional proposals to restructure the Medicare program did not address Medigap insurance.

Employers may also restrict choice by offering only a limited number of plans. Some employers, for instance, allow their Medicare-eligible beneficiaries only one choice of supplemental insurance coverage. Others offer coverage only through one or more managed-care options. In either case, the beneficiary's ability to chose among traditional Medicare and Medicare managed-care options may be limited.

POLICY APPROACHES TO ADDRESS SUPPLEMENTAL COVERAGE AND MEDICARE

These issues could be addressed in a variety of ways, ranging in scope from small, incremental changes to existing supplemental insurance to a full restructuring of the secondary insurance market. Within this spectrum, the options for change can be divided into three broad approaches: modifying current supplemental insurance, encouraging insurers to experiment with partial risk-sharing arrangements, and allowing or requiring insurers to assume full financial risk for Medicare and supplemental benefits. Each might address the spillover effects of supplemental coverage on Medicare, while preserving the availability of supplemental benefits.

Each of these approaches already exists in the current Medicare program. Medicare SELECT, for example, attempts to reduce the costs associated with stand-alone secondary insurance through the use of a network-model supplemental plan. Demonstration projects such as Medicare Choices and the Part B Capitation demonstration provide voluntary opportunities for secondary insurers to accept greater risk for covered health benefits. Finally, the Medicare risk-contracting program and the Medicare Insured Group (MIG) demonstration allow secondary insurers to assume full financial risk for their enrolled beneficiaries.

The following discussion describes how these approaches are being used under Medicare and outlines alternatives for broader implementation. Each approach has both benefits and drawbacks; these tradeoffs must be considered. For example, the Commission recognizes the fundamental tension between the desire to provide adequate financial protection to beneficiaries and the need to control Medicare costs. This potential tradeoff lies at the center of any debate over changes to the secondary insurance market.

Incremental Changes to Supplemental Insurance

The first broad approach is to modify Medigap insurance in the context of the current program to make such coverage cost Medicare less. Medicare SELECT attempts to do this by incorporating differential cost-sharing requirements, based on the beneficiary's choice of provider. This year the Commission examined this broad approach by focusing on Medicare SELECT.

Other potential policy options to modify supplemental insurance as it now exists include creating catastrophic Medigap insurance, reexamining and possibly reformulating the 10 standard Medigap plans to incorporate some beneficiary cost sharing or deductible payments, creating an approved menu of supplemental benefits that could be selected or offered in any combination, creating uniform rating and underwriting standards, or taxing supplemental insurance. The Commission may examine some of these options in more detail next year.

Medicare SELECT: An Innovation in Medigap Insurance. The Medicare SELECT demonstration was established under OBRA90 as a short-term offering in only 15 states. In 1995, Medicare SELECT was extended for three more years and broadened to all 50 states. This legislation (P.L. 104-18) also authorized a permanent extension of the program unless the Secretary of HHS determines that it does not offer beneficiaries lower premiums than traditional Medigap policies, or that it results in higher Medicare costs or diminished access to care for Medicare beneficiaries. Medicare SELECT policies are required to conform to one of the 10 federally standardized Medigap policies.[22]

Medicare SELECT is a form of Medigap insurance that, in exchange for typically lower premium costs, limits full supplemental coverage to services provided by a preferred provider organization or other restricted network or HMO, to the extent that such networks are in place. Like Medigap, Medicare SELECT operates on a fee-for-service basis with Medicare paying its traditional 80 percent of allowed charges (less the deductible) for Part B services as well as its usual share of Part A charges. SELECT insurers are, however, only required to offer full reimbursement of coinsurance and supplemental benefits for services provided by network providers and for emergency out-of-area care. They may reimburse all or part of the cost-sharing requirements for services obtained out of network, but are not obligated to do so. As of November 1995, the Medicare SELECT program covered about 489,000 (2.8 percent) of the 18.3 million Medicare beneficiaries in 14 states, and SELECT policies were offered by more than 50 different insurers and HMOs.[23]

Networks created by SELECT insurers can include physicians, hospitals, pharmacies, and other allied health professionals. Although they do not have to meet all the standards for Medicare managed-care plans, insurers or HMOs wishing to offer SELECT policies must demonstrate that their network offers sufficient access to enrolled beneficiaries and employs an ongoing system of quality control. They are also required to inform beneficiaries, in writing, about restrictions on coverage for out-of-network services and out-of-area use (emergency or otherwise) at the time of purchase. Additionally, they must offer prospective buyers the option to purchase any alternative traditional Medigap policy and provide a continuous conversion option to a traditional Medigap policy with no preexisting condition exclusions or medical underwriting (Schaeffer 1996).[24] Medicare SELECT is the only restricted-network Medigap product available to Medicare beneficiaries.[25]

Concerns have been raised about the prevalent use of age-attained rating for Medicare SELECT premiums, and whether beneficiaries purchasing SELECT policies will be subjected to medical underwriting if they

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[22] In the three states with waivers of Medigap standardization requirements (Massachusetts, Minnesota, and Wisconsin), SELECT policies are required to conform to the state's guidelines for Medigap insurance.

[23] The 15 states participating in the initial demonstration are: Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington, and Wisconsin. As of November 1995, Massachusetts had no Medicare SELECT policies available.

[24] Much of the factual information on the SELECT program and its implementation comes from the Congressional Research Service's report on Medicare SELECT, the Research Triangle Institute's *Evaluation of the Medicare SELECT Amendments Case Study Report*, and the *Evaluation of the Medicare SELECT Amendments: A Summary of Empirical Findings to Date* (CRS 1995b; RTI 1994; RTI and HER 1995).

[25] With the enactment of Medicare SELECT, OBRA90 disallowed the continuation of network-based supplemental insurance that existed in various forms prior to the legislation's enactment in the 35 states not participating in the SELECT demonstration.

decide to switch to traditional Medigap insurance later in life. In response to these concerns, P.L. 104-18 requires GAO to report to the Congress on options for modifying Medigap market rules to ensure that continuously insured Medicare beneficiaries can avoid these barriers to switching Medigap policies.

To date, Medicare SELECT is saving money primarily for beneficiaries through premiums that cost, on average, 15 percent to 20 percent less than traditional Medicare supplements.[26] Some advocates note that the lower premiums for SELECT plans allow some beneficiaries to purchase Medigap policies who could not otherwise afford to do so (Musser 1995).

Although some SELECT plans use a range of managed-care techniques to control costs, the primary sources of savings in SELECT premiums are discounting arrangements with SELECT network hospitals.[27] These arrangements typically include the hospital's waiving or discounting of the Part A deductible and coinsurance requirements for SELECT beneficiaries. Similar arrangements with physicians are not possible under Medicare's anti-kickback provisions.[28] SELECT physician networks must base payments on the Medicare Fee Schedule. Consequently, SELECT plans can only require that the plan's participating physicians accept Medicare's allowed charge as payment in full for all services.[29]

Although the final evaluation has not been completed, early indications are that the Medicare program is not realizing across-the-board decreases in the costs and utilization of services among SELECT beneficiaries. Preliminary evaluations indicate that Medicare SELECT is associated with significant increases in Medicare spending in 5 of the 11 states analyzed and significant decreases in Medicare costs and utilization in 4 others.[30]

Medicare SELECT may not adequately address concerns about the cost implications of secondary insurance for Medicare. Discounts negotiated with network providers benefit the SELECT insurers—and by extension, the beneficiary—by lowering the costs of supplemental coverage, but Medicare continues to

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[26] This is HHS's estimate of the premium savings in Medicare SELECT. According to the NAIC, Medicare SELECT beneficiaries save 10 percent to 37 percent. These two different estimates reflect the difficulties inherent in comparing non-equivalent plans.

[27] Some SELECT plans choose providers based on performance and quality criteria and use provider profiling techniques to monitor utilization and practice patterns. The use of these techniques by SELECT insurers tends to reflect the maturity of the managed-care market in the individual state (Schaeffer 1996).

[28] Under many SELECT contracts, hospitals are forgiving or discounting and absorbing the cost of the deductible and cost-sharing requirements for Part A services. This is allowed under an OIG-created Part A safe harbor and does not result in any Medicare savings. Because the OIG views physician discounting arrangements as potential violations of Medicare anti-kickback provisions, it has indicated that it will neither create a Part B safe harbor nor allow any Part B discounting or alternative payment arrangements between physicians and plans.

[29] If a SELECT plan wanted to pay physicians on a capitated, salaried, or discounted fee-for-service basis, the plan would have to share any of the cost savings from those arrangements with the Medicare program.

[30] The five states experiencing significant growth in costs were Alabama, Arizona, Indiana, Texas, and Wisconsin. The states experiencing a significant decrease in costs were California, Florida, Missouri, and Ohio (RTI and HER 1995). The final report on Medicare SELECT was submitted to the Health Care Financing Administration on December 7, 1995, and is currently under review.

pay its regular rates (and most costs) for all services provided. As a result, the supplemental insurer's incentives to control costs are limited. Meaningful volume reductions will likely require greater incentives. In addition, Medicare SELECT may not fully address the spillover effects of first-dollar coverage on the Medicare program.

Partial Risk Demonstrations

A second approach to changing supplemental insurance is to create opportunities for secondary insurers to accept partial risk voluntarily for both Medicare and supplemental benefits, as under the Medicare Choices and Part B Capitation demonstrations. This year, the Commission focused on these types of programs as the principal options to encourage supplemental insurers to bear some of the costs of supplemental benefits. Other options, such as increased cost-sharing requirements for beneficiaries with secondary insurance and lump-sum payments to Medicare by supplemental insurers, might be considered in the future.

Medicare Choices Demonstration. The Medicare Choices demonstration allows a range of managed-care and provider organizations to experiment with a variety of different payment arrangements for care provided to Medicare beneficiaries.[31] It is geared to attract the participation of PPOs, open-ended HMOs, integrated delivery systems, and primary care case-management models (HCFA 1995a). Payment mechanisms used in the demonstration could include risk corridors, blended capitation and fee-for-service payments, full capitation, or any other type of payment arrangement that would share financial risk between the plan and Medicare. Participating plans will have the opportunity to experiment with the provision of supplemental benefits and reduced cost-sharing requirements. Because applications for participation are currently being reviewed, it is too soon to tell how many will incorporate supplemental benefits. This demonstration presents an opportunity to learn about effective methods of limiting the impact of secondary insurance on beneficiaries' health care costs.

HCFA's Part B Capitation Demonstration. The Health Care Financing Administration (HCFA) conducted one demonstration project that modified the health care prepayment plan (HCPP) contract by capitating all Part B services. Authorized in the original Medicare legislation, HCPPs are a form of Medicare managed care that consists of cost contracts for Part B services only. Under an HCPP contract, the contracting health plan is paid all reasonable costs for Part B services provided through the plan. Medicare pays for other out-of-network Part B services and for all Part A services directly. These plans are not required to meet open-enrollment, guaranteed access, or enrollee-mix standards (CRS 1995a). As of December 31, 1995, unless they are eligible for an employer-plan exclusion, HCPPs must comply with Medigap rules and can offer only supplemental packages that match 1 of the 10 standardized Medigap plans.

Under the Part B Capitation demonstration, all Part B services were capitated while Part A services remained directly payable by Medicare. This demonstration, conducted with the United Mine Workers

[31] See Chapter 2 for more information on the Medicare Choices demonstration.

of America (UMWA), ran from July 1990 to June 1995 and covered about 88,000 Medicare-eligible retirees and dependents. Although the project was evaluated, no reliable conclusions about its effectiveness could be drawn because of a number of changes that occurred within the UMWA plan during the same period (Abt Associates 1995). HCFA is negotiating another waiver with UMWA to continue the project.

Approaching Full Risk: Integrated Insurers

A final approach to modifying secondary insurance would be to require supplemental insurers to accept full risk for all Medicare and supplemental benefits. The voluntary Medicare risk-contracting program and the MIG demonstration are examples of this approach. These programs require participating insurers to assume full financial risk for all basic and supplemental benefits provided to enrolled beneficiaries. These arrangements attempt to control Medicare costs by sharing or passing the risks for excess utilization onto the participating plans. A similar option that might be considered in the context of a restructured Medicare program that offers a broader choice of health plans is full replacement, or unified, insurance.

Medicare Risk-Contracting Plans. Under the Medicare risk-contracting program, managed-care plans receive a monthly capitation payment for each enrollee. The plan is then responsible for covering all Medicare benefits and any supplemental benefits it has agreed to provide. Plans may charge a monthly premium to cover cost sharing and extra benefits, but many do not.

Medicare Insured Group Demonstrations. OBRA87 authorized three MIG demonstrations under which HCFA could contract with self-insured employer or union-sponsored health plans to provide all Medicare-covered services and supplemental benefits to the employer's or union's Medicare-eligible retirees. Companies participating in the MIG demonstrations are paid on a capitated basis, with payments based on cost projections derived from the individual group's previous claims experience. The capitation payment is set at 95 percent of projected costs.[32] The employer or union is entitled to keep up to 5 percent of profits, and any excess profits must be returned to the beneficiary in the form of extra benefits. Participating plans must meet the same requirements for quality, access, financial solvency, and marketing as Medicare risk-contracting plans.

The MIG demonstrations are based on the premise that employer-sponsored plans will be able to use their bargaining power to reduce the costs of care. Savings are also expected to be generated through use of various utilization review mechanisms. In addition, by allowing Medicare-eligible retirees to remain in their employer health plan after qualifying for Medicare, MIG programs are intended to support continuity of care.

HCFA awarded five different cooperative agreements to employer and union organizations to develop MIG demonstration projects. After completing feasibility studies, however, four declined to pursue a MIG

[32] This method of setting the capitation rate reflects that which is used to set the adjusted average per capita cost (AAPCC) for risk- or cost-contracting HMOs, except that the AAPCC is based upon total fee-for-service experience in a given area rather than on a specifically defined population.

contract, citing limited opportunities for savings, the unlikelihood of being able to negotiate provider payments that were less than Medicare's, high administrative costs, inability to negotiate a satisfactory contract with a delivery system, and inexperience with managed care or the lack of an existing managed-care network (HCFA 1995b). One organization further cited Medicare's lower administrative costs, significant start-up costs, and concern over biased selection into the MIG plan as reasons not to pursue a demonstration project (Maher 1995). One company did pursue a MIG demonstration, but withdrew during the final waiver approval process. To date, the company has not explained its withdrawal and is reportedly pursuing a Medicare risk-contract instead (*Managed Care Week* 1996).

One caveat to the MIG approach is that, unless the employer's insurance is more efficient than Medicare, the loss of the Medicare subsidy for supplemental benefits will require employers to either raise their own or their employee's contributions to health care costs or reduce the benefits they offer to beneficiaries over time.

Unified Insurance. Under a restructured Medicare program, capitated Medicare plans would become the primary payers for their enrollees. If secondary coverage is available to supplement these plans, they too may be affected by the issues now confronting Medicare. For example, supplemental coverage among beneficiaries enrolled in new Medicare plans may result in increased costs and utilization within their plans. As mentioned previously, different rating and underwriting standards among plans raise artificial barriers to choice and would also have to be addressed within a unified insurance system.

In simple terms, unified insurance would prevent insurers from supplementing other insurers' products. All insurance to supplement basic Medicare benefits would become replacement insurance. Unified insurance policies would keep insurers from passing costs on to other insurers and eliminate the external impact of first-dollar coverage on the Medicare program. Although unified insurance is one way of creating a more competitive Medicare market, it represents a significant departure from the current system. The ramifications of such a move are not currently well-understood and would have to be identified.

Unified insurance would consist of two distinct policies. The first policy would consist of full replacement insurance only (FRIO) requirements, and the second would create a high-low option Medicare program.

A FRIO policy would require supplemental insurers to assume the responsibility for covering Medicare-covered services, plus any other benefits directly supplementing basic Medicare benefits that they offered. It would result in a de facto requirement that supplemental insurers either become full-risk insurers or discontinue offering supplemental coverage. As with the current Medicare risk-contracting program and the proposed multiple choice Medicare systems, Medicare would pay each participating plan a capitated amount. The plan would then pay for the cost of all basic and supplemental benefits and could collect a premium from enrollees.[33]

Full replacement requirements would have different effects, depending on whether Medicare is restructured. If Medicare were restructured to broaden beneficiary choice of health plans, this approach

[33] Current Medicare managed-care plans are essentially full replacement plans. FRIO and high-low option Medicare would not prevent insurers from offering supplemental coverage for benefits not covered by Medicare.

would effectively ban secondary insurance coverage for Medicare benefits, although coverage for non-Medicare covered benefits could still be sold. If Medicare is not restructured, FRIO requirements not only would ban supplemental benefits, but would effectively create a system offering multiple health plans that resembles the proposals now under discussion.

The second policy, a high-low Medicare option, would allow Medicare beneficiaries to select from a variety of plans offered by the traditional Medicare program. In a high-low option system, Medicare would give beneficiaries a choice of Medicare-administered plans, each offering some different combination of supplemental benefits, cost-sharing requirements, and annual caps on out-of-pocket expenses. Each of these new, more complete Medicare products would be offered at a premium price that reflected the full costs of the coverage it provided. The low-option Medicare plan would cover Medicare's current benefits package.

Proposals for unified insurance are often discussed only in terms of private insurers' offerings. It is important, however, that a high-low option Medicare program and a FRIO requirement be considered in tandem to ensure that replacement insurers and Medicare could compete on equal footing. Enacting either of the two policies in isolation could disadvantage Medicare. If, for example, high-option Medicare were enacted alone, these plans might not be able to compete on the basis of price with supplemental-only products, which would continue to be heavily subsidized by Medicare. Alternatively, FRIO alone would make traditional fee-for-service Medicare the only plan that could offer no supplemental benefits. Implementing the two policies together would allow beneficiaries to choose between a supplemented, traditional Medicare plan and a replacement insurer's plan that also covered supplemental benefits.

Individual beneficiaries with supplemental insurance could be differentially affected by premium price changes resulting from the implementation of FRIO and high-low Medicare. Currently, the typical beneficiary pays for Medigap insurance and, due to first-dollar induced utilization, increases costs to the Medicare program. As a result, the premium for the typical high-option Medicare plan (which would cover all Medicare cost-sharing and deductibles) should exceed the low-option Medicare premium by the price of the Medigap premium and the extra utilization it encourages. If these policies were implemented, however, it is likely that the premium for the traditional Medicare option would be significantly reduced and the premium for a high-option Medicare plan would increase only marginally over the current cost of Medigap insurance. This could occur because Medicare's current costs for first-dollar induced utilization would be reallocated across all beneficiaries. As a result, Medicare beneficiaries selecting low-option Medicare might see their costs decline, while those selecting high-option coverage would probably see their costs rise only minimally (assuming that they had and paid for supplemental coverage before). Beneficiaries participating in plans with Medicare risk-contracts would be unaffected by these policy changes.

Other Options. Both the Congressional Budget Office (CBO) and the American Medical Association (AMA) have proposed variants on this approach to expanding Medicare benefits. Unlike the high-low option Medicare proposal outlined above, CBO and the AMA would offer only a single high-option Medicare product.

In its 1991 report on restructuring health insurance for Medicare enrollees, CBO proposed a number of options for changing Medigap and Medicare insurance in order to limit the total financial liability of Medicare beneficiaries. The basic CBO proposal would cap the out-of-pocket liability for Medicare beneficiaries and prohibit secondary insurance from covering those out-of-pocket costs, effectively introducing a catastrophic coverage benefit into Medicare. Another broad option proposed by CBO would also restructure Medicare's cost-sharing requirements. It would be possible, under both general CBO proposals, to add coverage for prescription drugs or other supplemental benefits, and vary beneficiaries' maximum out-of-pocket expenses. The particular strength of the CBO proposal is that caps on out-of-pocket expenses could be formulated in a budget-neutral manner (CBO 1991).

The AMA has suggested a similar proposal to eliminate current Medicare cost-sharing requirements, cover supplemental benefits, and create a single yearly deductible for all Medicare-covered services. Extra supplemental benefits not included in the expanded Medicare options could continue to be offered by private insurance companies.

COMMISSION WORK PLAN

The Commission recognizes that supplemental coverage is extremely important to many Medicare beneficiaries and that it may protect beneficiaries from the potentially large costs associated with serious illness. Thus, the advantages and disadvantages of any changes to Medigap insurance must be carefully weighed. The costs to Medicare of the current system of supplemental insurance cannot be ignored, however, and must be considered in the context of a competitive market. With these considerations in mind, the Commission will continue to look at a variety of options to modify secondary insurance for Medicare beneficiaries during the year ahead. It will examine the implications of each and focus more closely on evaluating the feasibility and effects of any proposed changes on beneficiaries, supplemental insurers, and the Medicare program.

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The Changing Labor Market for Physicians

In 1990, the Congress expanded the Commission's mandate to include examination of the supply and specialty mix of physicians. The addition of this topic to the Commission's work stemmed from concerns that an oversupply of physicians might undermine other efforts to bring health care costs under control, and that the nation was training relatively too many specialists and relatively too few physicians in generalist fields (family practice, general internal medicine, and general pediatrics).

Responding to this change in its mandate, the Commission spent considerable time reviewing data on physician supply and distribution; studying related public and private-sector efforts; examining the impact of previous policy initiatives; and hearing from physicians, policy experts, medical educators, and others knowledgeable in these areas. These activities led the Commission to conclude that there was a need to slow growth in the aggregate supply of physicians and reach a more appropriate balance across specialties. In its 1993 and 1994 annual reports, the Commission recommended a new system for financing graduate medical education that would limit future growth in resident supply, rationalize the allocation of residency positions, and make entities sponsoring training programs more accountable to the nation's health care needs.

With policymakers' attention now focusing on the potential benefits of a competitive health care market, some have argued that the problems of physician oversupply and specialty imbalance are among those that will be resolved by the market. The mechanism for this change, it is argued, will be the growth of cost-conscious integrated health systems that alter the number and mix of services used by patients and thus the

This chapter examines:

- *Changes in the market for health services that affect the physician work force*
- *Signals of change in physician specialty mix*
- *Signals of change in demand for physicians overall*

number and mix of health professionals needed to provide those services. These developments will theoretically result in physicians being employed at greatly reduced compensation or being unable to find jobs in medicine, thus sending a signal to students and educators to change their behavior. Others doubt that market forces will lead to significant change and have thus called for direct action by policymakers, educators, and payers to address concerns about supply and specialty mix. This view is reflected in the recent reports of the Institute of Medicine and the Pew Health Professions Commission (IOM 1996; Pew Health Professions Commission 1995).

In its *Annual Report to Congress 1995*, the Commission examined whether changes in the organization and financing of health care were affecting the labor market for physicians. Two types of change in the labor market were assessed: if there was evidence that increasing demand for primary care physicians was leading to changes in specialty mix, and if there was any indication that the market was creating incentives to train fewer physicians overall. The Commission found that while there had been some changes in relative incomes and specialty choice, it was still too early to know whether these signaled a departure from previous trends.

This year, the Commission once again has taken a systematic look at whether and how the labor market for physicians is changing.[1] Anecdotes continue to abound about the lack of job opportunities for newly trained specialists, growth in incomes for primary care physicians and losses for specialists, and reductions in residency positions and programs. The available data suggest that change is occurring but that it is more modest than suggested by anecdotes. Moreover, growth in the number of international medical graduates (IMGs) in training may overwhelm any changes made in response to market dynamics by U.S. graduates. Because most data sources are national in scope, it is difficult to know whether change is most pronounced in the most competitive markets.

MARKETS RELEVANT TO THE PHYSICIAN WORK FORCE

As the Commission noted in its 1995 annual report, in considering whether market forces will lead to changes in physician supply and specialty distribution, it is important to recognize that there are actually two markets of interest: the market for physicians' services and the market for physician training. This distinction matters for two reasons. First, market pressures may lead to diametrically opposed responses from the two markets. That is, while organized systems of care may be demanding fewer physicians and relatively more primary care physicians than in the past, teaching hospitals, under significant pressure to economize, may be more dependent than ever on using residents to meet service needs. Moreover, even if graduates of U.S. medical schools begin to respond to market pressures by increasingly seeking positions in primary care fields, hospitals may continue to meet their staffing requirements by filling positions with IMGs.

Second, notwithstanding substantial changes in the market for physicians' services, the length of the training pipeline and the large stock of practicing physicians will preclude any substantial short-run impact

[1] This chapter does not address the important issue of how market forces might affect the geographic distribution of physicians. Views differ as to whether the growth of integrated delivery systems will reduce or increase the number of underserved areas.

on supply and specialty mix. For example, a large increase in starting salaries for primary care physicians will not likely affect the behavior of individuals who have just begun training in surgical specialties. As a result, one would expect that indicators measuring the production of physicians would lag behind those measuring changes in the practice environment. Furthermore, given the size of the pool of practicing physicians, even substantial changes in the behavior of recent graduates will have only a small impact on the size and composition of the physician work force.

CHANGES IN THE SPECIALTY MIX OF PHYSICIANS

There are several indicators of potential changes in the mix of physicians in different specialties: relative incomes, the availability of jobs, medical students' expressed specialty preferences, and the types of residency positions sought by graduating medical students. These indicators provide evidence that the market is signaling a modest shift in demand toward generalist physicians.

Changes in Relative Incomes

Generalists' incomes appear to be improving relative to those of specialists (Table 17-1). The American Medical Association's (AMA) recently released income figures for 1994 indicate that while median real incomes for all physicians declined from the previous year, real incomes for those in family practice and internal medicine fell less than those for most specialists (Moser 1996). Median incomes across all physician specialties continue to remain far apart, however, at nearly $272,000 for orthopedic surgeons and about $110,000 for those in family practice.

Expectations about starting salaries are also another potential barometer of income shifts between generalists and specialists. The 1995-96 survey of physician income expectations, sponsored by Physician Services of America, indicates that the gap in expected incomes has narrowed somewhat between generalists and specialists (Table 17-2) (Physician Services of America 1995).[2] Median income expected by family physicians and internists increased by $20,000 and $25,000, respectively, while income expectations for several other specialties, including anesthesiology, obstetrics-gynecology, and radiology, decreased.[3] It remains unclear whether salary expectations accurately reflect job offerings, whether there is a lag between reduced availability of jobs and changes in expectations about income, and whether such expectations are a good indicator of changes in specialty mix.

Changes in Jobs Available by Specialty

Many expect the growth of managed-care organizations to result in increased job opportunities for primary care physicians and fewer positions for specialists. Although there is relatively little systematic

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[2] Physician Services of America is a national physician recruiting firm that annually surveys approximately 33,000 residents, fellows, and young physicians. Respondents are asked what they expected to earn in a first job.

[3] Although the median expected salary for anesthesiologists declined by $12,000, the expected range decreased dramatically by $100,000.

Table 17-1. Real Median Physician Income, by Selected Specialties and Selected Years
(1994 dollars in thousands)

Specialty	1981	1985	1990	1991	1992	1993	1994
Primary Care							
Family practice	$125	$106	$107	$108	$106	$113	$110
Internal medicine	147	138	137	137	137	154	150
Pediatrics	113	105	115	115	118	123	110
Surgery							
General surgery	206	212	195	187	190	231	200
Ophthalmology	*	*	202	220	185	187	175
Orthopedics	*	*	309	257	264	277	272
Other Specialties							
Anesthesiology	206	191	229	230	232	226	200
Obstetrics/gynecology	192	168	211	220	201	205	182
Psychiatry	123	121	123	121	127	123	120
Radiology	203	206	229	245	253	246	220
All Specialties	161	154	149	153	156	160	150

SOURCE: American Medical Association Socioeconomic Monitoring System.

* Not available.

NOTE: Values have been adjusted for inflation using the gross domestic product deflator.

information on the availability of jobs in different fields, two recently completed studies suggest that marketplace demand for physicians is changing. The first adapted a methodology used by the Bureau of Labor Statistics that treats help-wanted advertisements as a proxy for demand, finding substantially decreased demand for specialists and steady demand for generalists (Seifer et al. 1995). Between 1990 and 1995, there were steep declines in the number of advertisements for specialists. The most dramatic drop was for physicians in internal medicine subspecialties. Only family medicine exhibited continuous growth in the number of positions advertised.

The second study surveyed residency program directors about the employment experience of their recent graduates, their perceptions about the difficulties in getting jobs (particularly in clinical practice), and actions they are taking at the program level to respond to those issues (Miller et al. 1996). Physicians in generalist fields were reported to have less difficulty finding positions than those in specialties. For example, just 3.2 percent of those in internal medicine reported difficulty finding a full-time clinical position compared to 25.5 percent of trainees in anesthesiology, 20.8 percent in plastic surgery, and 21.1 percent in gastroenterology. The percentages of those who actually failed to find full-time employment, however, were much lower at 6.6 percent for anesthesiology, 9.9 percent for plastic surgery, and 3.7 percent for gastroenterology.

Table 17-2. Trends in Salary Expectations for Residents and Physicians New to Practice for Selected Specialties (dollars in thousands)

Specialty	Range and Median Salary Expected				
	1990*	1991*	1993	1994	1995
Primary Care					
Family practice	$70-90	$75-120	$75-140 (100)	$80-150 (100)	$95-150 (125)
Internal medicine	65-80	80-90	95-125 (100)	80-150 (100)	100-150 (120)
Pediatrics	60-80	70-90	70-120 (85)	70-150 (100)	90-150 (100)
Surgery					
General surgery	80-120	90-120	120-250 (135)	100-230 (150)	125-230 (165)
Ophthalmology	80-120	80-120	125-300 (172)	80-200 (120)	70-200 (130)
Orthopedics	120-150	120-150	125-300 (175)	100-300 (162)	130-300 (180)
Other Specialties					
Anesthesiology	100-140	115-150	100-350 (150)	100-350 (162)	90-250 (150)
Obstetrics/gynecology	100-125	100-150	120-250 (150)	100-250 (180)	120-250 (170)
Psychiatry	90-100	90-110	60-180 (120)	90-250 (120)	90-250 (130)
Radiology	115-150	125-150	100-350 (160)	100-350 (165)	100-300 (150)

SOURCE: Physician Services of America.

* Medians not available for 1990 and 1991.

NOTE: Respondents were asked what they hope to make as a first-year salary. The sample size for this survey is approximately 33,000 with a response rate of about 85 percent.

Changes in Medical Students' Expressed Career Preferences

The plans of graduating medical students also suggest a trend toward generalism. In 1994, the percentage of senior medical students expecting to be certified in generalist fields increased for a third year in a row (Table 17-3). More than 27 percent signaled their intention to take generalist training compared with fewer than 15 percent in 1991. In addition, seniors expressed declining interest in highly specialized fields, including internal medicine subspecialties, ophthalmology, orthopedics, and anesthesiology (AAMC 1995b).

These figures continue to be difficult to interpret as an indicator of market change, however. First, interest in generalist careers continues to be lower than it was in 1980 or 1985. Second, it is not clear what is motivating the change. Either managed-care growth has finally become significant enough to affect medical students' perceptions about their future job opportunities, or enhanced efforts by medical schools to interest students in primary care careers (such as preferential admissions policies and required clerkships in family practice) are finally having an impact.

Table 17-3. Career Preferences Expressed by Graduating Medical Students for Selected Years, 1980-1995 (percentage)

Specialty	1980	1985	1991	1992	1993	1994	1995
Primary Care	31.0%	29.8%	14.9%	14.6%	19.3%	22.8%	27.6%
Family practice	14.5	13.3	9.4	9.0	11.8	13.1	15.7
Internal medicine	10.6	10.7	2.9	3.2	4.5	6.2	7.7
Pediatrics	5.9	5.8	2.6	2.4	3.0	3.5	4.2
Surgery							
General surgery	4.8	6.2	2.1	2.1	2.1	3.0	3.4
Ophthalmology	3.5	3.6	3.4	3.4	3.2	3.4	3.0
Orthopedics	4.8	5.7	4.7	5.3	4.8	5.0	4.5
Other Specialties							
Anesthesiology	2.3	5.7	7.0	6.8	5.7	4.7	2.9
Medical subspecialties	3.7	10.6	16.0	16.4	14.2	12.2	12.0
Obstetrics/gynecology	4.2	5.4	2.5	2.7	3.1	3.8	4.0
Psychiatry	2.8	4.2	2.1	1.6	1.5	2.0	2.2
Radiology	3.8	5.7	7.7	7.2	7.3	6.6	6.7

SOURCE: 1980-1995 Association of American Medical Colleges Medical School Graduation Questionnaire.

NOTE: Percentages based only on students who had decided on a specialty. Data since 1991 based on slightly different question format.

Types of Residency Positions Sought by Graduating Students

While expressed career preferences may signal a change in students' perceptions about the labor market, changes in behavior may be more accurately captured by the types of residency positions these individuals actually seek as they leave medical school. Data from the National Resident Matching Program (NRMP), however, provide a mixed picture about labor market changes.[4]

On one hand, more senior medical students are now seeking positions in generalist fields. In the spring 1995 match, match rates for all primary care fields increased, both overall and for graduates of U.S. medical schools (Tables 17-4 and 17-5).[5] Match rates for U.S. graduates only in several other specialties are on the decline, suggesting that U.S. students may be more responsive to labor market changes than their peers who graduate abroad.

[4] As part of the National Resident Matching Program, senior medical students submit their rank-ordered preferences for residency positions and residency program directors submit a rank-ordered list of students. A matching algorithm assigns students to programs with results for all students and programs announced in March of each year. Programs that do not fill all of their positions through the match may fill these positions with either unmatched students or international medical graduates before the training year begins in July.

[5] It is important to remember, however, that residents matching in generalist fields may pursue subspecialty training after completion of their initial residency.

Table 17-4. Overall Match Rate for Selected Specialties and Selected Years, 1985-1995 (percentage)

Specialty	1985	1990	1991	1992	1993	1994	1995
Primary Care							
Family practice	80.0%	70.4%	65.0%	67.5%	77.3%	82.7%	87.1%
Internal medicine	90.5	83.2	80.6	85.4	88.1	88.6	92.0
Pediatrics	89.0	81.4	78.7	82.1	87.0	92.1	95.7
Surgery							
General surgery	88.9	75.8	97.8	99.0	99.1	98.8	99.4
Orthopedics	98.8	99.3	98.1	99.2	99.4	99.6	100.0
Other Specialties							
Anesthesiology	93.1	82.2	80.9	77.6	72.3	64.3	54.2
Obstetrics-gynecology	94.9	97.0	97.2	96.6	98.3	98.7	96.5
Pathology	60.0	60.1	62.2	61.6	67.5	75.6	83.8
Psychiatry	81.9	76.0	71.5	64.2	64.6	67.7	78.1
Radiology	89.7	99.7	62.2	61.6	67.5	75.6	83.8

SOURCE: National Resident Matching Program.

NOTE: Ophthalmology excluded due to the small number of positions offered through the matching program.

Table 17-5. Match Rates for Graduates of U.S. Medical Schools for Selected Specialties and Selected Years, 1985-1995 (percentage)

Specialty	1985	1990	1991	1992	1993	1994	1995
Primary Care							
Family practice	68.5%	59.3%	55.7%	56.2%	63.2%	66.7%	70.8%
Internal medicine	74.2	61.4	57.1	55.9	53.1	53.9	57.9
Pediatrics	67.8	62.7	64.5	64.2	66.7	69.6	72.9
Surgery							
General surgery	80.6	66.6	88.0	88.6	84.6	87.3	88.9
Orthopedics	87.2	87.7	88.0	89.9	88.0	87.5	88.7
Other Specialties							
Anesthesiology	90.4	78.2	75.1	69.3	61.2	54.9	37.1
Obstetrics-gynecology	81.1	86.0	86.2	85.2	86.2	84.8	84.9
Pathology	40.6	50.0	52.6	49.0	53.8	56.7	61.4
Psychiatry	66.5	58.5	58.3	48.6	45.2	43.9	49.6
Radiology	83.3	76.6	78.6	79.4	81.8	77.9	69.2

SOURCE: National Resident Matching Program.

NOTE: Ophthalmology excluded due to the small number of positions offered through the matching program.

On the other hand, total match rates in many nonprimary care specialties also continue to increase except for anesthesiology (Table 17-4). In addition, interest in these fields among U.S. students continues to outpace the number of positions offered (Table 17-6).[6] Despite numerous anecdotes about the soft job market for anesthesiologists, the number of U.S. graduates seeking anesthesiology residencies in the 1995 residency match far outnumbered the number of first-year positions available (0.6 positions per interested student compared with 1.2 for family practice and 1.5 in internal medicine) (Table 17-6). Other specialties with low position-to-student-interest ratios include dermatology (0.3), radiation oncology (0.1), diagnostic radiology (0.7), plastic surgery (0.4), and orthopedics (0.8) (NRMP 1995).

Table 17-6. Number of First-Year Residency Positions Offered in the Match per Applicant for Selected Specialties, 1995

Specialty	Positions per Applicant
Primary Care	
Family practice	1.2
Internal medicine	1.5
Pediatrics	1.2
Surgery	
General surgery	1.1
Orthopedics	0.8
Other Specialties	
Anesthesiology	0.6
Obstetrics-gynecology	1.0
Pathology	1.4
Psychiatry	1.7
Radiology	0.7

SOURCE: National Resident Matching Program.

NOTE: Ophthalmology omitted due to the small number of positions offered through the matching program.

Changes in the Mix of Residency Positions and Programs

Data from the resident match can be difficult to interpret as indicators of labor market change for several reasons. First, the number of positions that happen to be offered through the match varies annually.[7] Therefore, lower match rates do not necessarily suggest that a field is less desirable; it

[6] Match rates can decline even when there is substantial interest in a field if there is a mismatch between student and program rankings. Many students who do not secure positions in the NRMP do end up getting residency positions by applying directly to programs between March and July.

[7] In some specialties, such as family practice and internal medicine, virtually all positions are offered through the match. In others, some programs do not participate in the match. Another complicating circumstance is that in fields such as anesthesiology and diagnostic radiology, some programs match for first-year residents and others for second-year residents.

could mean simply that more positions are being offered. Second, because it is geared to graduating medical students, the match does not encompass those fields that are entered in later years (for example, training in internal medicine subspecialties begins after completion of a residency in internal medicine). For this reason, it is difficult to tell from match data whether a higher match rate in internal medicine signals increasing interest in general internal medicine or in more specialized fields.[8]

Because of these problems in interpreting match data, a better measure of potential changes in specialty mix is the mix of first-year residents (Table 17-7). In 1994, the share of first-year residents in primary care fell slightly, from 59 percent to 57 percent. An increase in the share of trainees in family practice was offset by a large drop in the number of first-year residents in internal medicine.

Table 17-7. Percentage of First-Year Residents, by Selected Specialties and Years, 1980-1994

Specialty	1980	1986	1990	1993	1994
Primary Care	54%	57%	57%	59%	57%
Family practice	13	13	11	12	13
Internal medicine	32	34	36	36	34
Pediatrics	10	11	11	11	10
Surgery					
General surgery	14	13	13	12	12
Orthopedics	1	1	1	2	2
Other Specialties					
Anesthesiology	3	2	2	1	1
Obstetrics-gynecology	7	6	5	5	6
Pathology	3	2	2	2	2
Psychiatry	6	5	5	5	5
Radiology	2	1	2	2	2

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

NOTE: Percentages do not add to 100 because some specialties are not displayed.

It is also worth noting that some residency programs are making curriculum changes to respond to the demand for generalists. In a survey of internal medicine training programs conducted by the Association of American Medical Colleges and the Association of Professors of Medicine, 35 percent of those responding reported making changes in their program to train more general internists. Strategies included converting positions from preliminary internal medicine to general or primary care internal medicine,

[8] There is a substantial amount of "branching" from primary care training into nonprimary care fields. Of the graduating class of 1991, about 28 percent of those training in pediatrics and 52 percent of those training in internal medicine are expected to subspecialize (Killian 1996).

adding more ambulatory training time, and adding electives in disciplines such as dermatology and women's health (AAMC 1995a).[9]

CHANGING DEMAND FOR PHYSICIANS

Both the market for physicians' services and the market for training appear to be signaling that there are too many physicians overall. Median physician income fell last year, for the first time since the AMA began collecting these data. Moreover, the number of first-year residents declined in all fields except for family practice (Table 17-8).[10] As a result, while the total number of residents continued to grow, the increase was substantially less than in previous years.[11]

Despite slowed growth in the total number of trainees and numerous anecdotal reports about training programs closing, the size of the American graduate medical education enterprise has not changed dramatically. In fact, between 1993 and 1994, the total number of training programs grew slightly as a result of increases in family practice programs. The most substantial recent decreases have been in anesthesiology (Table 17-9).[12]

Some institutions have voluntarily reduced slots in anticipation of diminishing support from Medicare. For example, Duke University plans to trim up to 30 percent of its positions within 5 years, while in Boston, Massachusetts General and Brigham and Women's Hospitals have announced intentions to reduce slots by 20 percent by the year 2000 (Kostreski 1995). These actions suggest that some academic medical centers are beginning to respond to the incentives in the practice market. Given the length of the training pipeline and the uneven response of academic institutions, however, these efforts may have only a slight impact on the supply of physicians. Moreover, they are not necessarily representative of the typical response of educators. In the survey of training program directors mentioned above, for instance, 82 percent of program directors in anesthesiology reported anticipating employment problems for the 1994-1995 cohort of trainees but only 60.6 percent planned on reducing positions in response to these problems (Miller et al. 1996).

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[9] There are several different types of training programs in internal medicine. Preliminary programs provide training that serves as a prerequisite to training in internal medicine subspecialties or other medical fields. Primary care and general internal medicine programs prepare trainees for practice as internists.

[10] This drop is not evident in a similar data set maintained by the Association of American Medical Colleges and may represent the effect of more stringent data cleaning practices recently instituted by the AMA. Additional years of data will be needed to clarify whether the drop is real or an artifact.

[11] The total number of residents is a function of both the size of each cohort that enters training and the length of training. Since the mid-1960s, the average length of training has grown from a little over three years to about five years. This change reflects the increasing specialization of physicians (for example, the growth of internal medicine subspecialties that require additional training after completing a three year residency) and changing length of training in many fields.

[12] The number of residents per program varies substantially across specialties as well as across programs within a single specialty.

Table 17-8. First-Year and Total Residents for Selected Specialties and Years, 1980-1994

Specialty	First-Year Residents					Total Residents				
	1980	1986[a]	1990	1993	1994	1980	1986[a]	1990	1993	1994
Primary Care										
Family practice	2,371	2,281	1,934	2,503	2,512	6,344	7,238	6,680	7,976	8,587
Internal medicine	5,948	6,234	6,518	7,843	6,524	15,964	18,116	18,734	20,603	20,693
Pediatrics	1,864	1,938	1,937	2,454	1,999	5,171	5,817	6,115	7,460	7,394
Surgery										
General surgery	2,539	2,412	2,408	2,567	2,384	7,440	7,880	7,644	8,243	8,217
Ophthalmology	[b]	[b]	[b]	[b]	[b]	1,480	1,549	1,446	1,674	1,611
Orthopedics	218	257	269	353	311	2,418	2,822	2,630	3,029	2,903
Other Specialties										
Anesthesiology	523	325	358	314	258	2,490	3,864	4,889	5,696	5,490
Obstetrics/gynecology	1,220	1,048	1,000	1,121	1,097	4,221	4,525	4,315	5,074	5,046
Pathology	642	415	449	538	388	2,186	2,299	2,364	2,731	2,766
Psychiatry	1,063	980	874	1,096	899	3,911	4,892	4,673	5,044	4,979
Radiology	409	257	376	430	420	2,766	3,095	3,775	4,236	4,189
All Specialties	18,702	18,183	18,322	21,616	19,293	62,853	76,815	82,902	97,370	97,832

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

[a] Data from 1985 are not available.

[b] Residents may not enter training in ophthalmology in their first postgraduate year.

It should be noted, that between 1993 and 1994, the number of residents who were graduates of U.S. medical schools declined (Table 17-10). In addition, the total number of first-year residents fell by over 10 percent while the share of first-year residents who were IMGs increased substantially. These shifts suggest that behavioral changes by U.S. graduates are being mitigated by the ability of IMGs to secure residency positions.

Changes in college students' willingness to pursue medical careers might be a lagging indicator of a tightened labor market for physicians. To date, however, there is no evidence that changes in the organization and delivery of medical care are discouraging college students from becoming physicians. In fact, applications to allopathic medical schools, after falling during the 1980s, hit a record high in 1995 for the third year in a row with 45,657 applications (Page 1995).[13] Applications to osteopathic medical schools also rose in 1995 for the seventh straight year, for the first time exceeding 10,000 applications for 2,200 spaces (AACOM 1995). This trend is likely to continue given that plans are under way to open four additional osteopathic medical schools.[14]

[13] Despite the change in numbers of applications, enrollment in allopathic medical schools has remained relatively flat over the past decade.

[14] The four schools, which are in various stages of planning, would be located in Arizona, California, Florida, and Kentucky.

Table 17-9. Number of Residency Programs, by Selected Specialties and Selected Years, 1979-1994

Specialty	1979	1985	1990	1991	1992	1993	1994
Primary Care							
Family practice	385	385	383	393	395	407	430
Internal medicine	443	442	426	427	418	416	415
Pediatrics	245	236	215	217	214	215	215
Surgery							
General surgery	331	306	281	281	270	270	271
Ophthalmology	155	142	136	137	135	135	137
Orthopedics	180	168	163	161	161	161	160
Other Specialties							
Anesthesiology	161	165	155	157	155	155	149
Obstetrics-gynecology	304	292	275	273	273	274	273
Pathology	358	261	217	195	192	188	186
Psychiatry	223	211	196	200	197	198	196
Radiology	221	211	210	210	206	205	206
All Specialties	4,742	4,799	6,938	7,189	7,065	7,277	7,347

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

Table 17-10. Trends in the Number and Percentage of Residents Who Are International Medical Graduates for Selected Years, 1970-1994

Year	Total Number of Residents		Percentage Who Are International Medical Graduates	
	First-Year	All	First-Year	All
1970	11,552	39,463	29%	33%
1975	11,401	54,500	29	31
1980	18,702	61,465	21	20
1985	19,168	75,514	14	17
1990	18,322	82,902	19	18
1991	19,497	86,217	24	20
1992	19,794	89,368	25	20
1993	21,616	97,370	27	23
1994	19,293	97,832	36	24

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

Caution should be taken in interpreting changes in the number of applications to medical school as an indicator of change in the labor market for physicians, however. This is because employment prospects in other fields also influence students' willingness to apply to medical school. Uncertainty about future

prospects in law, business, engineering, and other professional fields thus may contribute to students' growing interest in medical careers.

Other changes such as the number of physicians taking early retirement or relocating might also be indicators of response to shrinking opportunities for physicians. While there is considerable anecdotal evidence that physicians are retiring, moving, and becoming more dissatisfied with their careers, there continue to be no good data sources to track these factors.[15] Similarly, changes in the roles of nonphysician practitioners who provide primary care services (for example, nurse practitioners and physician assistants) might also signal an oversupply of physicians. This is more difficult to measure, however, and may be confounded by current restrictions on payment and practice as well as the varying roles that these practitioners play in managed-care organizations.

CONCLUSIONS

The growth of integrated delivery systems appears to be having a modest effect on the national labor market for physicians. The lack of data at the market level precludes our ability to determine whether these changes are more pronounced in the most developed markets. National data indicate that positions in generalist fields are becoming somewhat more attractive but changes in relative incomes have been modest. Overall job opportunities for physicians also appear to be contracting. Still to be determined is the impact that the growing number of international medical graduates now in training will have on the labor market for physicians.

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The Medicaid Program: Current Design and Options

Medicaid is a joint federal-state entitlement program providing payment for medical services to about 37 million low-income persons who are aged, blind, disabled, or members of families with dependent children. It has three distinct features: joint federal-state financing, state administration in accordance with broad federal standards, and eligibility tied to state standards for other cash benefits. Thus, although broad federal guidelines determine eligibility and coverage standards, each state designs and administers its own Medicaid program. As a result, state programs vary considerably in eligibility requirements, service coverage, utilization limits, provider payment policies, and use of managed care.

This chapter presents background information useful for understanding the current policy debate, beginning with a description of the financing and structure of the Medicaid program as well as a discussion of the relationship between Medicaid and Medicare. It then describes current proposals to change the Medicaid program. Regardless of the particular changes that might be made to the program, the Commission remains concerned about the lack of systematic monitoring of access to health services among Medicaid beneficiaries. This issue is discussed in Chapter 19.

This chapter includes:

- *The financing and structure of the current Medicaid program*
- *The relationship between Medicare and Medicaid*
- *Current proposals to change the Medicaid program*

MEDICAID PROGRAM

Since its creation 30 years ago, the Medicaid program has undergone considerable growth in beneficiaries and expenditures, and incremental modifications of policies. Despite this growth, many of the basic program features, such as

financing, have not changed. This section describes Medicaid expenditures, eligibility, service coverage, and the relationship between Medicaid and Medicare.

Expenditures

Much of the criticism of the current Medicaid program focuses on rising expenditures. As the program is now structured, federal and state governments have difficulty controlling Medicaid spending.

Financing. Medicaid is jointly funded by the states and the federal government. The federal share of expenditures is determined by a formula based on state per capita income, under which states with relatively low per capita incomes receive higher federal matching rates (Table 18-1). For example, Mississippi, with per capita income that is less than 70 percent of the national average, had a matching rate of about 79 percent, while Connecticut, with per capita income that is nearly 135 percent of the national average, received a 50 percent match.[1] Since 1987 this matching rate has been recalculated annually. Overall, federal funds accounted for about 57 percent of total Medicaid spending in 1995.

Federal payments to the states are provided from general revenues to match expenditures submitted by the states. There is no limit on the total amount of federal payments. States may finance their share entirely from state funds or require local governments to finance up to 60 percent of program costs. Only 14 states exercised the latter option in 1991, with local dollars accounting for a small proportion of state financing in most of these states.

Patterns in Program Spending. In 1966 spending for Medicaid and its predecessor, the Kerr-Mills medical assistance program, accounted for $1.5 billion or 3.7 percent of the nation's personal health care expenditures (Lazenby et al. 1986).[2] By 1993, Medicaid's spending had increased to $112.8 billion and its share had climbed to 14.4 percent of personal health care expenditures. During this same period, the number of Medicaid beneficiaries grew from 11.5 million to 33.4 million (HCFA 1995).[3]

Recently, state spending for Medicaid has been growing faster than any other category of state expenditures except for corrections. In fiscal year 1994, total state Medicaid expenditures rose 12.3 percent. Medicaid now accounts for 19.2 percent of state expenditures and is the second largest category of

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[1] The federal match for Medicaid services is legislatively set at a minimum of 50 percent and maximum of 83 percent. Program administration costs are matched at 50 percent, and higher matching rates are provided for data systems operations and quality monitoring efforts.

[2] The Kerr-Mills program provided federal matching grants for medical care furnished to the low-income elderly. Although the program had the potential to extend services to a substantial proportion of the elderly population, it was viewed primarily as a supplement to existing forms of public assistance and as a means to shift the burden of financing to the federal government. Medicaid expanded and replaced the Kerr-Mills program (Stevens and Stevens 1974).

[3] For more information on the growth in Medicaid spending, see Chapter 1.

Table 18-1. Medicaid Matching Rates, per Capita Income and Poverty Rate, by State (percentage)

	Federal Medical Assistance Percentage	Per Capita Income as Percentage of U.S. Average	Poverty Rate
Alabama	71.22%	81.9%	17.9%
Alaska	50.00	111.2	9.5
Arizona	65.90	87.1	14.8
Arkansas	74.46	76.6	18.5
California	50.00	107.1	16.8
Colorado	54.30	102.8	10.1
Connecticut	50.00	134.6	8.8
Delaware	50.00	105.1	8.7
District of Columbia	50.00	140.1	20.7
Florida	54.78	99.2	16.5
Georgia	62.47	92.0	15.5
Hawaii	50.00	112.1	9.0
Idaho	70.92	83.3	14.2
Illinois	50.00	108.0	14.5
Indiana	63.49	91.2	13.1
Iowa	63.33	89.2	10.6
Kansas	59.52	95.4	12.2
Kentucky	70.91	81.2	19.3
Louisiana	73.49	79.0	22.9
Maine	61.96	90.3	14.5
Maryland	50.00	115.8	10.0
Massachusetts	50.00	117.9	10.3
Michigan	56.37	98.0	14.3
Minnesota	54.65	101.2	12.1
Mississippi	78.85	69.8	24.6
Missouri	60.64	94.2	15.2
Montana	71.05	82.6	14.9
Nebraska	61.98	94.9	10.3
Nevada	50.31	108.9	11.7
New Hampshire	50.00	107.9	8.7
New Jersey	50.00	129.0	10.2
New Mexico	74.17	77.7	20.2
New York	50.00	119.5	15.5
North Carolina	65.14	88.7	14.5
North Dakota	71.13	82.9	12.4
Ohio	60.83	94.1	13.1
Oklahoma	70.39	81.8	18.8
Oregon	62.12	93.1	12.4
Pennsylvania	54.61	102.3	12.1
Rhode Island	53.87	101.2	10.7
South Carolina	71.08	80.6	18.0
South Dakota	69.50	86.1	14.3
Tennessee	67.15	87.4	17.2
Texas	64.18	91.6	17.4
Utah	74.35	77.2	10.8
Vermont	59.55	93.2	11.4
Virginia	50.00	104.0	9.5
Washington	54.24	105.2	10.8
West Virginia	75.72	77.1	20.7
Wisconsin	60.47	94.7	11.2
Wyoming	65.63	94.6	11.5
U.S. Average	---	100.0	14.6

SOURCE: Government Accounting Office 1995.

NOTE: Federal Medical Assistance Percentage is for 1994. Income and poverty are for 1991-1993.

state spending after elementary and secondary education (National Association of State Budget Officers 1995).

Medicaid spending differs dramatically by state (Table 18-2). In 1993 the average annual payment per recipient of Medicaid services ranged from $2,381 in Mississippi to $9,700 in New Hampshire. The average spending per poor person ranged from $276 in Utah to $1,275 in the District of Columbia (Liska et al. 1995).

While total state spending is a function of the actual number of Medicaid beneficiaries, differences in service coverage and payment policies are also contributing factors to spending differences across states. The pattern of Medicaid spending among service categories also varies by state. One state may put more money into long-term care, for example, while another state may emphasize inpatient hospital services.

Variation in states' total generosity for the Medicaid program is related to socioeconomic factors, especially wealth and the federal matching rate (Davidson 1980; Grannemann 1980; Holahan and Cohen 1986; Buchanan et al. 1991). Empirical evidence also suggests that states that are more generous in their funding for one aspect of Medicaid (e.g., eligibility, service coverage, and provider payments) tend to be less generous in others (Cromwell et al. 1987).

Eligibility for Medicaid

Many state officials complain that federal standards, including those for eligibility and coverage, limit a state's ability to respond to its unique circumstances. Medicaid includes federal eligibility rules that typically have been based on participation in other cash assistance programs. Because eligibility for these other programs can vary across states, so too does Medicaid eligibility. Most recent changes to federal eligibility rules have shifted from such program-based categories of eligibility to income-based definitions. The following discussion describes the evolution of current eligibility policies and the current composition of Medicaid beneficiaries.

Policies. As a means-tested entitlement program, eligibility for Medicaid was patterned after the earlier Kerr-Mills program and, until recently, has been closely linked to actual or potential receipt of cash assistance under various federal welfare programs. Persons qualify for coverage because they are either categorically needy or medically needy. All persons receiving Aid to Families with Dependent Children (AFDC) and most persons on Supplemental Security Income (SSI) are considered categorically needy and are covered in all states.[4] Certain groups that do not receive cash assistance are also defined as categorically needy.[5]

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[4] Twelve states exercise the more restrictive 209(b) option by limiting Medicaid eligibility for SSI beneficiaries to more restrictive standards that were in effect in the state before implementation of SSI.

[5] These include (1) persons whose cash payments would be less than $10, (2) families that lose AFDC benefits due to increased employment income, working hours, or child or spousal support payments, (3) persons who become ineligible for SSI due to increases in their Social Security benefits, (4) disabled persons who lose SSI due to employment income but who remain disabled and need Medicaid benefits to stay employed, and (5) children receiving federal adoption assistance or foster care maintenance payments.

Table 18-2. Medicaid Expenditures by State, 1993

	Total (millions)	Expenditures per		
		Capita	Poor Person	Medicaid Beneficiary
Alabama	$1,637	$401	$1,267	$3,139
Alaska	269	563	2,389	4,129
Arizona	n/a	n/a	n/a	n/a
Arkansas	1,031	430	1,421	3,058
California	13,538	448	1,862	2,801
Colorado	1,092	336	1,343	3,890
Connecticut	2,278	702	4,007	6,918
Delaware	253	361	1,572	3,670
District of Columbia	687	1,275	3,997	5,731
Florida	4,949	372	1,282	2,836
Georgia	2,799	441	1,554	2,938
Hawaii	381	369	1,778	3,464
Idaho	294	278	958	2,951
Illinois	4,981	421	1,582	3,571
Indiana	2,816	510	1,867	5,029
Iowa	987	348	1,405	3,442
Kansas	890	354	1,455	3,665
Kentucky	1,864	518	1,797	3,021
Louisiana	3,730	901	2,625	5,115
Maine	851	682	2,672	5,042
Maryland	1,960	420	1,972	4,443
Massachusetts	4,044	696	3,642	5,312
Michigan	4,363	472	2,003	3,728
Minnesota	2,167	498	2,165	5,135
Mississippi	1,196	450	1,243	2,381
Missouri	2,252	437	1,667	3,695
Montana	323	398	1,376	4,461
Nebraska	564	356	1,421	3,539
Nevada	423	338	1,362	4,789
New Hampshire	763	675	3,273	9,700
New Jersey	4,706	607	2,888	6,019
New Mexico	571	380	1,287	2,387
New York	19,628	1,104	4,852	7,162
North Carolina	2,896	447	1,698	3,224
North Dakota	270	447	1,660	4,344
Ohio	5,179	471	1,739	3,494
Oklahoma	1,090	349	1,167	2,962
Oregon	956	321	1,387	2,938
Pennsylvania	5,613	462	1,775	4,589
Rhode Island	829	872	3,962	4,337
South Carolina	1,682	483	1,720	3,623
South Dakota	266	389	1,266	3,846
Tennessee	2,675	543	1,805	2,946
Texas	7,119	422	1,467	3,084
Utah	478	276	953	3,224
Vermont	255	434	1,999	3,182
Virginia	1,792	300	1,329	3,114
Washington	2,316	479	2,388	3,659
West Virginia	1,200	671	2,049	3,459
Wisconsin	2,115	426	1,887	4,502
Wyoming	135	293	1,263	2,924

SOURCE: Liska et al. 1995

NOTE: Expenditures include disproportionate share hospital payments.

Beneficiaries are defined as individuals enrolled in the Medicaid program who actually receive medical services.

See data section for important details regarding the figures presented for select states.

Poor defined as the number of individuals under 150 percent of the federal poverty threshold, which was $11,817 for a family of three in 1995.

States have the option of considering other groups as categorically needy. These include "Ribicoff" children (those younger than a maximum state age limit and poor enough to meet AFDC income standards but who do not qualify for cash assistance for other reasons), institutionalized persons meeting state financial standards, and disabled children living in the community who would be eligible if institutionalized.

States also may give Medicaid eligibility to the medically needy. The medically needy are those individuals whose income or resources exceed standards for cash assistance but who meet a separate state-determined income standard and are also aged, disabled, or a member of a family with dependent children. Persons who "spend down" income and assets due to large health care expenses may qualify as medically needy. In 1993, 37 states extended eligibility to the medically needy.

As a result of Medicaid's eligibility linkage to eligibility for cash assistance programs, the program covered only about half the population with incomes below the federal poverty level. The Congress, however, has broadened the number of poor persons eligible for Medicaid by weakening this link between Medicaid and cash benefits since 1986. Expanded Medicaid eligibility has been targeted to specific populations, especially pregnant women and children.[6] As a result, the proportion whose eligibility was based on their welfare status dropped from 68 percent in 1990 to 60 percent in 1993 (Holahan et al. 1994).

Characteristics of Those Covered by Medicaid. In considering options to modify the Medicaid program, it is helpful to understand what populations the program covers.[7] In 1993 Medicaid beneficiaries included a disproportionate share of nonwhites, people living in poverty, young children, people in poorer health, and central city dwellers (Table 18-3). Children were four times more likely than adults to be on Medicaid. Those with excellent health and those with no activity limitations were underrepresented in the Medicaid population.

Expenditure Patterns by Eligibility Category. Patterns of service use and overall expenditures differ dramatically among the three major populations served by Medicaid: children and adults in families with dependent children, the elderly, and the disabled (Figure 18-1). Children and adults in families with dependent children accounted for 73 percent of Medicaid beneficiaries in 1993, but only 31 percent of program payments, excluding disproportionate share hospital expenditures.[8] By contrast, the elderly accounted for 33 percent of total spending, but only 12 percent of beneficiaries. Blind and disabled persons constituted 15 percent of beneficiaries, but accounted for 36 percent of payments. These differences are attributable largely to spending for long-term care for the elderly and disabled populations (CRS 1988).

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[6] A progression of laws through the mid- and late-1980s created specific eligibility for pregnant women, infants, and children under 6 in families with incomes up to 133 percent of the federal poverty level and for children under 18 in families with incomes below the poverty level. In addition, states can now receive federal matching funds for extending coverage to the aged and disabled with incomes below the poverty level and to pregnant women and infants in families with incomes up to 185 of the poverty level. States can cover other groups at their own expense.

[7] Among Medicaid beneficiaries, nearly one-fifth had some additional form of coverage. This rate varied across subgroups; among those over 65, for example, virtually all Medicaid beneficiaries were also covered by Medicare.

[8] Disproportionate share hospital expenditures are made to those hospitals that serve a disproportionate number of low-income patients.

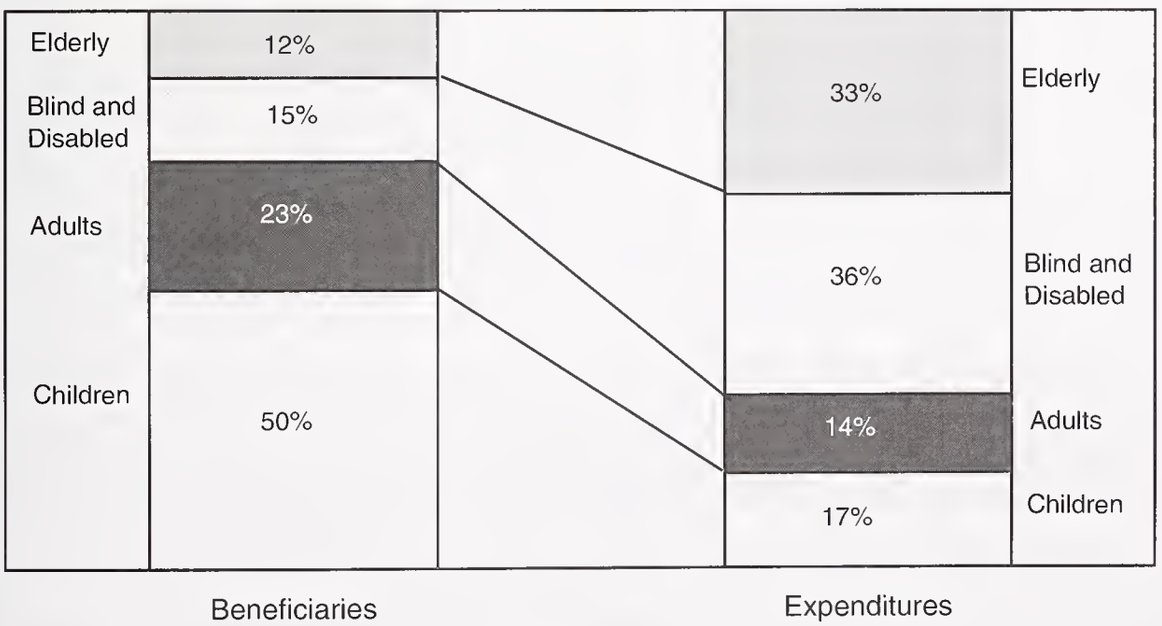
Table 18-3. Characteristics of U.S. Population, by Health Insurance Status (percentage)

	Percent of Population	Distribution by Insurance Status			
		Medicaid	No Insurance	Medicare, Private, Military	Unknown
Overall	100%	9%	13%	69%	9%
Female	51	10	11	69	9
Nonwhite	17	20	16	52	12
Income below Federal Poverty Line	12	40	26	24	10
Unemployed	2	10	33	48	9
Report No Activity Limitations	85	7	13	70	10
Report Excellent Health	38	6	11	73	10
Report Poor to Fair Health	10	17	13	61	9
Under Age 6	9	24	9	56	10
Age 18-64	61	5	16	69	10
Age 65 and Over	12	6	1	87	6
Central City	31	14	15	60	11

SOURCE: Physician Payment Review Commission analysis of the National Health Interview Survey 1993 Insurance Supplement.

NOTE: Respondents are categorized as having Medicaid regardless of other coverage.

Figure 18-1. Medicaid Beneficiaries and Expenditures by Enrollment Group, 1993 (percentage)



SOURCE: Kaiser Commission on the Future of Medicaid, 1995a.

Medicare Buy-In Arrangements

In considering proposals to restructure Medicaid and Medicare, it is important to understand the relationship between these programs. Several federal requirements provide for Medicaid coverage of poor Medicare beneficiaries. Under these state buy-in arrangements, beneficiaries typically receive help meeting Medicare copayment requirements and deductibles and may also be eligible for additional benefits beyond those covered by Medicare. State Medicaid programs serve Medicare beneficiaries in two distinct ways. First, they pay Medicare premiums and cost-sharing expenses for certain types of beneficiaries. In addition, they may provide benefits to those Medicare beneficiaries who qualify for the state's Medicaid program. In either case, Medicare is the primary insurer for these beneficiaries. The federal government partially reimburses states for their buy-in expenditures through the normal Medicaid grant formula.

Beneficiaries Who Qualify for Medicaid Benefits. The largest group of Medicare beneficiaries covered by Medicaid buy-in agreements consists of those qualifying for Medicaid. Such dual-eligibility may result from being medically or categorically needy. The federal government reimburses states, using the match formula, only for Medicare deductibles and coinsurance for medically needy beneficiaries; states themselves are fully responsible for paying for the premiums. For the categorically needy, by contrast, states are reimbursed for all Medicare expenses according to the usual match rate. For Medicaid services, such as prescription drugs and nursing home care, the federal government reimburses states according to the usual match rate.

Beneficiaries Who Qualify for Cost Sharing and Premium Assistance. Certain low-income Medicare beneficiaries may be eligible for Medicaid coverage of Medicare premiums and cost sharing, even if they do not otherwise qualify for assistance. These beneficiaries receive Medicaid assistance because of concerns that they are unable to meet Medicare's financial requirements or, in order to do so, would face perverse work incentives.

Federal law defines two groups—Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs)—who may receive such assistance. QMBs, whose incomes are below the poverty level and whose resources do not exceed 200 percent of that allowed under SSI, receive state assistance with both Part B premiums and cost sharing.[9] SLMBs, who have incomes up to 120 percent of the poverty level and must meet the same resource standards set for QMBs, receive Part B premium support. States are reimbursed for all expenditures for QMBs and SLMBs at their usual match rate.

Besides requiring states to provide support to these low-income beneficiaries, federal law also includes provisions to reduce the incentives for low-to-moderate income disabled people to stop working in order to continue Medicare coverage. States are required to pay the Part A premiums of these Qualified Disabled and Working Individuals (QDWIs). QDWIs are those disabled persons who would lose Part A coverage if they returned to work, but who also are not eligible for Medicaid. Additionally, they cannot have incomes

[9] QMBs who must pay Part A premiums receive Medicaid support for those premiums as well.

exceeding 200 percent of the poverty level and resources exceeding twice the SSI resource standard.[10] QDWIs with incomes between 150 percent and 200 percent of the poverty line may be required by states to pay some share of premiums on a sliding scale. States are reimbursed by the usual matching formula for their QDWI expenditures.

Service Coverage and Limitations

Under the current program all states must provide a standard benefit package to the categorically needy that includes inpatient and outpatient hospital services; physician services; laboratory and X-ray services; family planning; skilled nursing facility (SNF) services for adults; home health care for persons entitled to SNF services; rural health clinic services; nurse-midwife services; and early and periodic screening, diagnosis, and treatment (EPSDT) for children.

The required benefit package for the medically needy is less comprehensive. States opting to cover the medically needy must, at a minimum, furnish ambulatory care for children and prenatal care and delivery services for pregnant women. Almost all states that have medically needy programs, however, provide the same services to both medically and categorically needy beneficiaries.

States may also provide (and receive federal matching payments for) other services, including prescription drugs; dental care; eyeglasses; services provided by optometrists, podiatrists, and chiropractors; intermediate care facility (ICF) services; and services to the mentally retarded in ICFs. The states vary considerably in the optional services they offer. Virtually all cover prescription drugs, ICF services, and optometrists' services. Regardless of the services a state chooses to offer, it must do so uniformly throughout the state, providing comparable coverage to all categorically needy beneficiaries and allowing beneficiaries to obtain services from any qualified provider.

States have broad discretion in defining coverage for both mandatory and optional services. They may impose time or frequency limits on coverage, such as ceilings on inpatient days or physician visits. In 1993, 49 states limited physicians' services to categorically needy beneficiaries in some way (HCFA 1993). They may also establish utilization controls such as medical necessity reviews, prior authorization for certain services, or second surgical opinion programs.

Some states have instituted beneficiary cost sharing as a form of utilization control. Federal statute constrains the use of this strategy, however, to nominal copayments only (for example, $1 per physician visit) and to certain groups of beneficiaries. Certain services, such as pregnancy and emergency care, are statutorily exempt from copayment requirements. Providers may not deny services if a beneficiary cannot pay the cost-sharing amount.

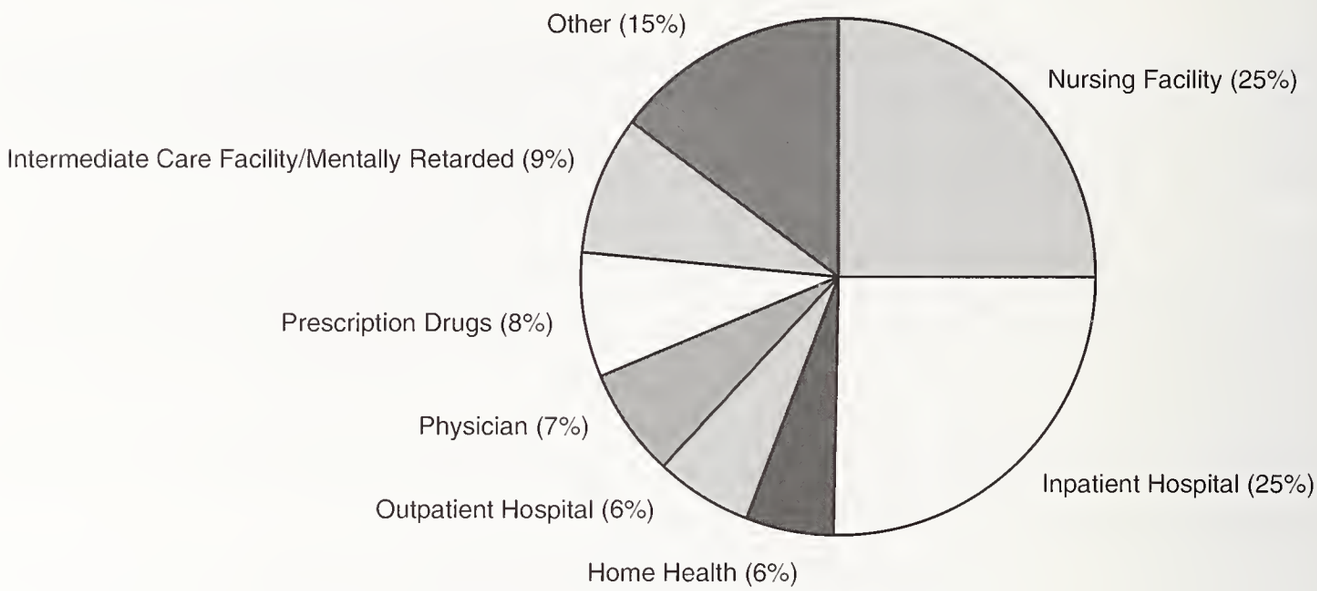
Intermediate nursing facility care (for both the mentally retarded and other beneficiaries) and inpatient hospital services accounted for the largest shares of Medicaid payments, about 34 percent and 25 percent

[10] A person is not considered disabled by the Medicare program if he or she is able to work. Therefore, those whose disability does not preclude working but would otherwise qualify them for Medicare coverage faced an incentive to not work before the QDWI program was created.

of payments, respectively, in 1993 (HCFA 1995) (Figure 18-2). Other types of services represented much smaller proportions of expenditures (for example, physicians' services accounted for 7 percent).

Based on the number of users of services, prescription drugs are the largest Medicaid service category, followed closely by physicians' services and then distantly by outpatient hospital services. Nearly 24 million Medicaid beneficiaries used prescription drugs and physicians' services in 1993. This compares with 16 million using hospital outpatient department services and nearly 6 million using inpatient hospital services (HCFA 1995).

Figure 18-2. Distribution of Medicaid Payments, by Type of Service, 1993



SOURCE: Health Care Financing Administration, 1995.

Waivers

Certain provisions of the current Medicaid law, such as the requirement that beneficiaries have the freedom to choose their providers, discourage the development of managed care, while other provisions, such as federal eligibility standards, discourage the use of federal monies to broaden coverage to other populations in need of health insurance. States may obtain waivers of Medicaid requirements from the Health Care Financing Administration (HCFA) to design programs without these constraints. There are several different types of Medicaid waivers; these vary in the amount of flexibility allowed and in the provisions of the Medicaid law to which they apply. The two types of waivers are program waivers under Section 1915 of the Social Security Act, and demonstration waivers granted under Section 1115 of the

Social Security Act. This section describes each of these.[11] It is followed by a discussion of development of managed care under the Medicaid program.

Section 1915 Program Waivers. Section 1915 waivers permit states to mandate enrollment in managed care and develop home-based and community-based care programs as well as programs for so-called boarder babies—infants with acquired immunodeficiency syndrome or drug dependency who remain in the hospital because they cannot be placed in adoptive or foster care homes. Applications for these waivers are highly standardized. This is the most commonly used waiver authority.

Under Section 1915(b), HCFA can waive certain federal requirements (freedom of choice, uniform statewide operation, and comparability of benefits) to allow states to implement alternative health delivery systems or provider payment arrangements. To receive approval, a state must demonstrate that the program will be cost effective and that access to quality care will not be impaired. These waivers are granted for two years and can be renewed.

As of January 1995, 39 states had 1915(b) waivers for managed-care programs. Michigan, for example, has waivers that allow it to limit, in selected counties, Medicaid beneficiaries' choice of providers to primary care case management and health maintenance organizations (HMOs).

Home-based and community-based care waivers under Sections 1915(c) and (d) allow states to provide medical and supportive services for elderly, mentally retarded, and other disabled beneficiaries who are at risk of needing institutional care.[12] These waivers are for three years, but may be extended for five more. HCFA can waive the requirement that state policies apply across an entire state to allow for programs in limited geographic areas; it can also waive the comparability standards so that the state can limit benefits to certain categories of individuals. Typical services provided under these waivers include case management, home health aides, transportation, and personal care services. As of September 1995, 49 states had home-based and community-based waivers under Section 1915(c). Oregon had the only 1915(d) program.

Section 1915(e) allows for waivers to develop programs for boarder babies. A broad range of services is allowed under this authority, including physicians' services, nursing care, prescription drugs, and transportation. Although no state has been granted a waiver under this section, waivers to states for boarder baby programs have been granted under the authority in 1915(c) of the Social Security Act.

Section 1115 Demonstration Waivers. Section 1115(a) of the Social Security Act allows the Secretary of Health and Human Services (HHS) to approve demonstration projects that will help promote the goals of the Medicaid program. The Secretary has broad discretion in doing this and has selectively approved such proposals.

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[11] For a more extensive discussion of demonstration waivers, see Chapter 8 of the Commission's *Annual Report to Congress 1995.*

[12] The 1915(d) waivers are granted for programs for the elderly only.

The intent of this demonstration authority is to test unique and innovative approaches to the delivery and financing of health care (HHS 1984). Under a demonstration grant, the Secretary can waive many provisions of the Medicaid law.[13] All other sections of the Medicaid law, except those explicitly waived, still apply to demonstrations, however. Demonstrations require research and evaluation components.

These demonstrations are for a limited time, usually three to five years. These generally have not been renewed by the Secretary, but the Congress has extended them with legislation. Between 1984 and 1991, the Congress legislated 13 extensions of demonstrations (CRS 1993).

Responding to state officials' criticisms of the Medicaid program, the use of this waiver authority was expanded in amount and scope under the Administration. States are increasingly using this waiver authority to expand Medicaid eligibility for acute care services to low-income, uninsured persons; enroll Medicaid and newly covered beneficiaries in prepaid managed care; and gain flexibility in meeting federal Medicaid program requirements. As of February 1996, 10 states had implemented health reform projects under Medicaid demonstration authority, while an additional 5 states had approved demonstrations but had not implemented them.[14]

Alternative Delivery Systems. Most Medicaid services traditionally have been provided under fee-for-service arrangements. But the use of managed care has been rapidly expanding. In 1972 Medicaid had contracts only with the Health Insurance Plan of Greater New York, Kaiser Permanente in three states, and Group Health Cooperative of Puget Sound. The first concerted effort by a state to expand managed care occurred when California contracted with managed-care organizations in the early 1970s. Managed care has grown rapidly in Medicaid during the last few years—from only about 282,000 beneficiaries in 1981 to about 7.8 million beneficiaries (or 23 percent of the total beneficiaries) in 1994 (Kaiser Commission on the Future of Medicaid 1995b).

Use of managed care by states varies considerably. Some 15 states have more than 25 percent of beneficiaries in managed-care arrangements, while 27 states have fewer than 15 percent in such arrangements (Kaiser Commission on the Future of Medicaid 1995c).

Medicaid managed-care arrangements include HMOs, prepaid health plans (PHPs), health insuring organizations (HIOs), and primary care case management (PCCM).[15] HMOs provide comprehensive

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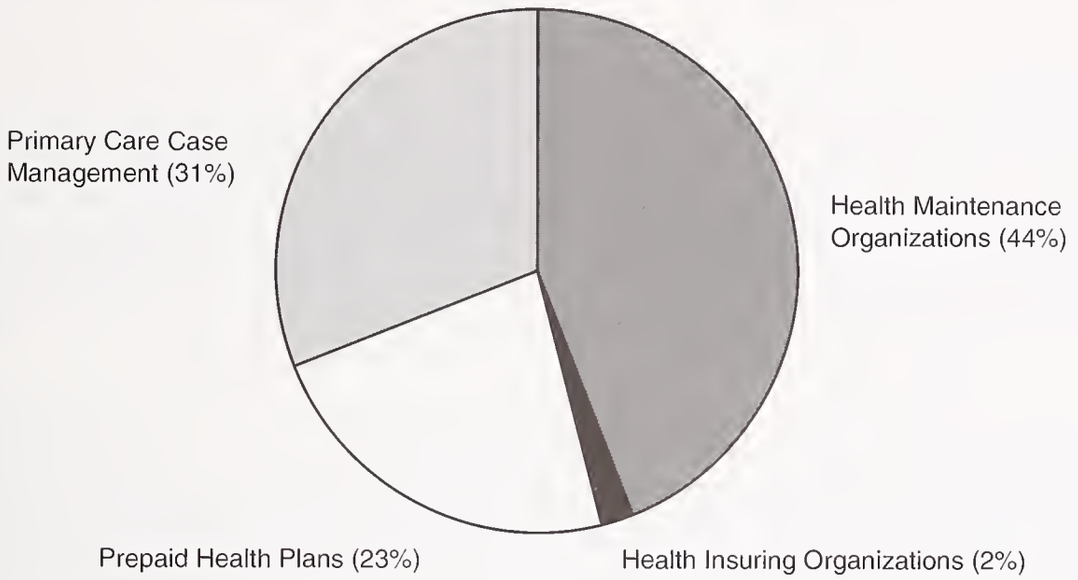
[13] The Secretary can waive requirements in or incorporated under Section 1902 of the Social Security Act.

[14] For more information on these demonstrations, see Rotwein et al. (1995), Thorne et al. (1995), and Riley (1995).

[15] PHPs are certain community, migrant, or Appalachian health centers located in medically underserved areas; organizations that contract with the state Medicaid agency for a less-than-comprehensive list of services or on a nonrisk basis; and organizations that are statutorily exempt from HMO requirements. HIOs pay for services of subcontracting providers and assume all financial risk in exchange for a premium. The HIO organizes the network of providers with preauthorization and utilization review to control the volume of services. The providers in the network serve as case managers and, in some HIOs, receive capitated payments. While HIOs function very much like independent practice associations, they include all physicians who are willing to abide by the specified contractual arrangements and all Medicaid beneficiaries who live in a designated area.

health services to Medicaid beneficiaries in return for a capitated payment that is based on expenditures for comparable beneficiaries in fee-for-service Medicaid. HMOs have 44 percent of those Medicaid beneficiaries enrolled in managed care (Figure 18-3).

Figure 18-3. Medicaid Managed-Care Enrollment, by Type of Plan, 1995



SOURCE: Health Care Financing Administration, 1995.

Under PCCM arrangements, a primary care physician coordinates and approves an array of services in addition to providing primary care services. In most PCCM systems, physicians are paid case management fees (typically $3 per beneficiary per month) in addition to their regular fee-for-service payments for the primary care services they provide. In others, physicians are placed at financial risk for some services (usually ambulatory care). Physicians may determine the level of their Medicaid caseloads, up to a state-specified limit. At present, primary care case management programs provide care to about 31 percent of Medicaid managed-care enrollees.

CURRENT PROPOSALS TO CHANGE THE MEDICAID PROGRAM

In 1995, both the Congress and the Administration proposed changes to the Medicaid program to limit growth in spending and permit more innovation in service delivery and payment. Their proposals represent two general approaches to restructuring the Medicaid program: block grants and limits on per capita expenditures. Although both proposals would provide for more flexibility to states in running the Medicaid program, there are major differences. The congressional proposal provides for more substantial changes and deeper cuts than the Administration's. The Administration's proposal retains some aspects of the current Medicaid program. A more recent proposal made by the National Governors' Association adopts elements from both approaches.

Congressional Proposal

The conference agreement passed by the Congress in November 1995 (H.R. 2491) calls for changing Medicaid into a block grant program (referred to as Medigrant) and reducing projected federal spending by $163 billion over seven years. Under the block grant approach to Medicaid, states would receive a set amount of federal funds to use in providing health care services to people with incomes below some threshold. In general, states would be able to decide which groups of poor people to cover with Medicaid and what services to provide them.

Program eligibility would be changed under the Medigrant proposal. Each state would decide who among those under 275 percent of the poverty line would be eligible for its Medigrant program. While eligibility entitlement for groups of individuals would be eliminated, states would be required to cover pregnant women or children under 13 whose family income is below the poverty level as well as disabled individuals as defined by the state. Additionally, money would be set aside for specific groups. States would be required to spend at least 85 percent of the average percentages they had previously for each of the following groups: poor families, low-income elderly beneficiaries, and low-income disabled individuals.

As for most other aspects of the program, the Medigrant proposal would allow states flexibility to design their programs. They would have complete freedom to select specific services to be provided (except for abortion), set payment levels, vary benefits by types of individuals and geographic areas, and use managed care. The proposal does not specify required quality assurance mechanisms for managed-care plans.[16]

The states are required to evaluate their programs. Not only must they establish strategic objectives and performance goals, but they must explain how these goals would be met. States must also describe the methods to measure goals, collect data on actual performance, and discuss whether the goals were met and any remedial actions implemented. During fiscal year 1998 and every third year thereafter, evaluations of the state program must be conducted by independent organizations. The state would have to collect utilization statistics for the program, although the level of detail required is unclear. A provision in the Senate version for monitoring the impact of Medicaid changes on the insurance status of children as well as retired and disabled persons was dropped by the conference committee.

Administration Proposal

The Administration has proposed a more modest set of changes to modify certain elements of the current Medicaid program. The proposal would require states to continue coverage of those currently covered under Medicaid; at their option, states could expand coverage to others whose incomes did not exceed 150 percent of the poverty level.

Under this proposal, states would be granted much more flexibility in program design and administration than is the case with the current Medicaid program, but less than under the congressional proposal.

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[16] For discussions of quality assurance in the Medicaid program, see the Commission's *Annual Report to Congress 1992* and *Annual Report to Congress 1993.*

Without the necessity of waivers, states would be allowed to adopt mandatory enrollment in managed care as long as beneficiaries would have the opportunity to choose among plans or providers. The Administration's proposal would repeal federal provisions on provider payments, including the Boren amendment, the requirements for comparable access to pediatric and obstetric services, and the requirement for cost-based payments to Federally Qualified Health Centers (FQHCs).[17] The required enrollment mix for managed care (the 75/25 rule) also would be repealed. States could adopt home and community-based services without obtaining waivers.

The Administration's proposal would set per capita limits on federal spending for Medicaid beneficiaries by type (aged, persons with disabilities, nondisabled adults, and non-disabled children). State spending for beneficiaries would be matched by the federal government up to those limits. The caps would be updated using a five-year rolling average of gross domestic product plus or minus a specific factor. States with demonstration programs would also be limited by per capita spending caps. The proposal also would reduce federal payments for disproportionate share hospitals and allow this money to be used to reimburse some other providers, such as FQHCs.

The Administration would modify Medicaid quality and access requirements for managed-care organizations to emphasize a quality improvement approach. States would have to establish access standards for managed-care plans, and collect and analyze data to monitor plans' performance. Providers serving Medicaid beneficiaries through managed-care arrangements would have to demonstrate their capacity to deliver services and would be required to have internal quality assurance programs that meet standards established by the Secretary. The current requirement for an external review of managed-care plans would be repealed.

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Monitoring Access for Medicaid Beneficiaries

Monitoring access in the Medicaid program is essential to make certain the program is achieving the federal goals it was designed to meet. With current legislative proposals recommending not only dramatic restructuring of Medicaid but also lower federal spending in the future, the monitoring activity is even more critical. The impact of any changes must be known, and new policies implemented successfully and refined as needed.

Just as tracking access under Medicare was seen as vital to understanding and improving physician payment reform in the early 1990s, so too must federal lawmakers understand the effects of any marked changes in Medicaid. Further, any efforts to hold states accountable for providing timely and appropriate care to Medicaid beneficiaries will require such monitoring, as will discerning how changes may affect those no longer covered. Regardless of whether new policies are implemented or the current program is maintained, the Commission reiterates its longstanding call for tracking access in the Medicaid program.

This chapter includes:

- *The Commission's previous work on access to care*
- *Various measures to track access*
- *Data needs and availability for monitoring access*
- *Steps in developing a Medicaid access monitoring system*

Recommendation

The Department of Health and Human Services should monitor access to care under the Medicaid program and the Secretary should report on Medicaid access to the Congress on a yearly basis. Access of those with Medicaid coverage and others whose incomes fall below a specified percentage of the poverty level should be monitored. Eventually, monitoring should include state-specific estimates of access. As part of this effort, the Department should:

- *continue its development of a uniform Medicaid claims and encounter data system,*

- *require nonparticipating states to participate in that system, and*
- *develop and administer a periodic access survey of Medicaid beneficiaries and others with incomes below a specified percentage of the poverty level.*

A congressional agency should be required to analyze and comment on the Secretary's report on Medicaid access just as the Commission now examines the Secretary's report on access under the Medicare Fee Schedule and suggests alternative approaches to analyzing access.

As the Commission's previous analyses of access in Medicare and Medicaid indicate, a comprehensive approach to access monitoring should be built from several different types of measures and data. In the case of current and former Medicaid beneficiaries, a monitoring strategy must reflect changes in coverage and delivery systems. For example, because states may differ in the policies they adopt, analyses should address geographic variation in access. Similarly, persons with different types of coverage may be affected in various ways. The experience of Medicaid beneficiaries enrolled in managed care may not be the same as that of beneficiaries covered by Medicaid fee for service or those who also have Medicare coverage. Since states may adopt a wide range of approaches to serving their Medicaid beneficiaries, the notion of coverage may in itself become difficult to define. States, for instance, could use Medicaid funds to implement a public health model of care delivery based on neighborhood clinics rather than providing insurance coverage to individuals. Finally, since certain groups of beneficiaries may have different experiences obtaining timely appropriate care, the experiences of children, pregnant women, the disabled, and the elderly should all be studied.

This chapter discusses strategies for monitoring access of those eligible for Medicaid, those formerly eligible, and those whose incomes are under a specified multiple of the poverty level. It begins by reviewing the Commission's efforts to monitor access in both Medicare and Medicaid. A discussion of the various kinds of measures that may be used to track access follows. The types of data needed for this activity and their availability are then reviewed. Finally, key steps needed to develop a monitoring system are presented.

As reflected throughout the chapter, current analyses of access rely heavily on fee-for-service claims data. As delivery systems change, the types of information available and, perhaps, the challenges to access will change, affecting the kind of data needed and access measures that should be tracked. Theoretically, managed-care organizations can develop encounter data that are very similar to claims data, so that claims-like access measures can be created for those in managed care. The relevance of certain utilization measures for managed care, however, may be unclear. Further, it may be difficult to adapt these patient-specific measures to the extent that states adopt dramatically different approaches, such as funding directly public health providers. Should this occur under Medicaid restructuring, the Commission will explore the ramifications. In particular, under such circumstances public health surveillance tools might be evaluated as possible access monitoring tools.

MONITORING ACCESS: THE COMMISSION'S PREVIOUS ACTIVITIES

The Commission has considered the issue of monitoring beneficiaries' access to appropriate, timely care within both the Medicare and Medicaid programs for several years. These activities have led it to look at appropriate access measures, availability of data, and comparability of measures across delivery systems. As part of its responsibility to report on access under Medicare, the Commission has developed and estimated a variety of measures. Its work on access in Medicaid has focused more on identifying potential data sources. Each of these activities is described in turn below.

Monitoring Access under Medicare

Since the Medicare Fee Schedule was implemented, the Commission has been responsible for reporting annually on beneficiary access to physicians' services within Medicare. As its work on monitoring access for the Medicare population has demonstrated, claims (or equivalent encounter data) and survey data hold considerable promise for monitoring access among Medicaid beneficiaries (PPRC 1995). The Commission has found that monitoring can be done in a timely fashion.

Among the tools the Commission has used to monitor access for Medicare beneficiaries are utilization, outcomes, and survey measures. The key strategy developed by the Commission compares these measures for groups thought to be at risk for diminished access with those for the broader Medicare population. In fact, these measures have shown that access is less for vulnerable populations than for the general Medicare population. Although access for most Medicare beneficiaries is considered to be good, both utilization and outcomes measures suggest problems for African American beneficiaries as well as for those in urban high-poverty areas and in Health Professional Shortage Areas (PPRC 1992; PPRC 1995). Estimates of clinically based indicators of access, for instance, show that African American beneficiaries are one-third less likely than their white peers to have a mammography examination every two years. Self-reported indicators of access available through the Medicare Current Beneficiary Survey (CBS) also suggest that these vulnerable groups have more difficulty in obtaining care (PPRC 1993b).

Provider participation is another measure of Medicare access. Surveys of physicians have been conducted by the Commission to monitor their attitudes toward Medicare. A major finding was that physicians were accepting new Medicare patients at nearly the same rates as they accepted private fee-for-service patients (Louis Harris and Associates 1993; NORC 1994). Based on claims data, an analysis of physicians' willingness to serve Medicare beneficiaries indicated that over time the physician-to-beneficiary ratio has increased, and that physicians who saw Medicare patients for the first time outnumbered those who stopped seeing them (PPRC 1994b).

In monitoring access, the Commission has used many data sources and types of measures. Utilization measures and physician participation have been based on claims files. Mortality rates have been calculated from enrollment files. Surveys have been used to gauge physicians' attitudes toward Medicare as well as to assess beneficiaries' usual source of care, perceived barriers to care, and satisfaction with care. As the Commission continues to refine its Medicare access monitoring activities, a major challenge is to develop measures applicable to managed-care enrollees. Claims-based analyses cannot be extended to this growing population

without complete, systematic encounter data from managed-care organizations. Therefore, survey-based measures may play a larger role in Medicare access monitoring until these data are more widely available.[1]

Monitoring Access under Medicaid

The Commission has developed a strategy to monitor access to care in the Medicaid program in response to its mandate under the Omnibus Budget Reconciliation Act of 1990 (OBRA90). Its Medicaid-related activities have been oriented more toward laying the groundwork for a monitoring approach, rather than actually developing estimates of particular access measures.

In fact, most of the Commission's recommendations in this area relate to the development of data resources. In its 1993 annual report, the Commission recommended that the Health Care Financing Administration (HCFA) develop a national Medicaid claims-based data file to use for monitoring access and other purposes (PPRC 1993a). The Commission, in its 1994 annual report, recommended that HCFA periodically survey Medicaid beneficiaries in all states to track access to care (PPRC 1994a). Previous Commission work, including the development and pilot testing of a potential Medicaid survey described below, may be useful to policymakers as they consider these issues.

ACCESS MEASURES FOR MEDICAID

It is helpful to separate what measures are useful for measuring access from what types of data are available, since the latter may differ across delivery systems and may change over time. Measures for monitoring access in Medicaid differ somewhat from those used in Medicare because of the populations served (for example, children versus the elderly) or the challenges to be overcome (such as language barriers or transportation problems). In addition, the growth of Medicaid managed care may affect the types of measures useful for describing beneficiaries' access.

Various measures might be appropriate for tracking changes in access in the Medicaid program. Some might be used for those formerly covered by Medicaid, and others for those currently covered.[2] Measures used to monitor access could include different indicators of insurance coverage, utilization of appropriate and timely care, aspects of care delivery, and health outcomes. Multiple measures are probably needed to monitor access in different states as well as for those served by different delivery systems and for different beneficiary subgroups.[3]

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[1] For more information on the Commission's approach to monitoring Medicare beneficiaries' access, see Chapter 12.

[2] Monitoring of those formerly covered by Medicaid could be done with population-wide measures, covering all those whose incomes fall below a certain percentage of the poverty level. For a discussion of the development of a population-based system, see Roos and her colleagues (1995) and Cohen and MacWillaim (1995).

[3] For a description of models and methods for measuring access, see Millman (1993).

Insurance Coverage

The proposed Medicaid policies, especially block grants to states, would likely change who the program covers. While greater program flexibility may enable some states to serve more people with the available funds, some formerly covered by Medicaid may no longer be eligible, losing their only insurance coverage. Previous studies have shown the importance of insurance for access to health care. When beneficiaries' eligibility for Medicaid terminates or when there are program cuts, access to health care diminishes and health status deteriorates (Lurie et al. 1984; Lurie et al. 1986). When Arizona did not have a Medicaid program, for instance, poor children saw physicians 40 percent less often than poor children in other states (Blendon et al. 1986).

It would be difficult to track Medicaid status of particular individuals over time. Nonetheless, monitoring the insurance status of those under a specified multiple of the poverty line would provide an indicator of changes in coverage for those who could be covered by Medicaid. An analysis of the Current Population Survey (CPS), for example, shows that among those with family incomes under 275 percent of the poverty line in 1993, 38 percent of individuals reported no insurance coverage; 21 percent reported that they had some sort of Medicaid coverage; and more than 40 percent had either Medicare, military, or private coverage (Table 19-1).[4] These estimates could serve as a baseline for comparing insurance status as captured by CPS or a similar survey in future years. If states use Medicaid resources to provide services directly, then analyses of insurance coverage may be of limited value in assessing access for Medicaid-eligible individuals.

Table 19-1. Individual Insurance Status by Family Income Relative to the Poverty Threshold, 1993 (percentage)

Family Income Relative to the Poverty Threshold	Individual Insurance Status			
	Uninsured	Any Medicaid	All Other	Total
Less than 125 percent	15	16	9	40
125 - 199 percent	12	3	15	31
200 - 275 percent	10	1	17	29
Total	38	21	42	100

SOURCE: Physician Payment Review Commission analysis of the Current Population Survey, March 1994 Supplement.

NOTES: This analysis is based on individuals with family income less than 275 percent of the poverty threshold.

Percentages may not sum to row or column totals due to rounding.

[4] This level (275 percent) was chosen because of the conference agreement, but its use is illustrative of the approach. Setting the level at 275 percent of the poverty level would include about half of the population. Although surveys should encompass a spectrum of income levels for the purposes of comparison, it might be appropriate to oversample those under a lower percentage of the poverty level (say, 150 percent or 133 percent) to monitor changes in access over time among more vulnerable populations.

Provider Participation

The extent of provider participation has been used as one indicator of access.[5] HCFA, for instance, uses provider participation as a standard for judging whether states have met the OBRA89 requirement that Medicaid beneficiaries have access to pediatric and obstetrical services comparable to the general population. States are considered to have met the standard if they can show that at least 50 percent of obstetric practitioners and pediatric practitioners, respectively, fully participate in Medicaid or that they participate at the same rate as they do in Blue Shield.[6] For such purposes, participation rates must be calculated at the county or other appropriate substate level. Researchers, too, used provider participation as an indicator of access. Some studies have shown that participation rates are affected by program features, like payment rates. Physicians are likelier to treat Medicaid patients if the fee levels are more comparable with those of other insurers (Mitchell 1991; Yudkowsky et al. 1990; Fox et al. 1992).

Using participation rates as the sole indicator of access is not sufficient, however. For example, other studies have found that while fee levels influence the site of service, they do not affect access to care. Medicaid beneficiaries in states with higher fees are likelier to receive care in physicians' offices. Conversely, those in states with lower fees are more likely to receive care in emergency rooms and hospital outpatient departments (Long et al. 1986; Cohen 1993). Based on participation rates, overall access to care may appear comparable in these two cases, but the timeliness, appropriateness, and continuity of care may differ.

Utilization Rates

Using utilization as an access monitoring tool may be easier for some subgroups of Medicaid beneficiaries than it is for Medicare beneficiaries because of consensus about the kind and amount of care certain individuals require. It is generally agreed, for example, that prenatal care should begin in the first trimester of pregnancy and that such care is always appropriate. Particular aspects of health care access relevant to the Medicaid population have been addressed in the literature and are highlighted here.

Preventive Services. The adequacy of health screening is an important indicator of Medicaid access, given the age of the population and the potential savings preventive care offers. Underservice can be evaluated by selecting subgroups of Medicaid beneficiaries for whom specific preventive care standards are established. Access to preventive services, for example, could be monitored by determining the proportion of Medicaid women having Pap tests at appropriate intervals and the percentage of Medicaid children under two years old who receive the recommended number of well-child visits and immunizations.

Prenatal Care. Aspects of Medicaid-financed pregnancy and post-delivery care can be tracked with detailed information about care throughout the maternity cycle. For example, several studies comparing the prenatal care and pregnancy outcomes for Medicaid fee-for-service beneficiaries with those in managed care concluded that there were no differences between delivery systems, but that Medicaid

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[5] Adoption of a direct-service model by states would limit the value of provider participation analyses.

[6] Full participation means accepting all Medicaid patients who present themselves for care. Obstetric practitioners include obstetrician-gynecologists, family practitioners, certified nurse-midwives, and certified family nurse practitioners. Pediatric practitioners include pediatricians, family practitioners, and certified pediatric nurse practitioners. If a county has only one such practitioner, 100 percent participation must be demonstrated.

beneficiaries receive fewer prenatal visits in either setting than the standard of care would prescribe (Carey et al. 1991; Goldfarb et al. 1991).

Other Ambulatory Utilization Measures. Broad measures of utilization, such as the number of physician visits in a year, site of care or the usual source of care, distance to care, and the availability of a usual source of care, have been used extensively by researchers studying access for the uninsured and for Medicaid beneficiaries (Wilensky and Berk 1982; Davis and Rowland 1983; Freeman et al. 1987; Rosenbach 1989). These studies found that the uninsured have lower rates of utilization of ambulatory services and are less likely to have a usual source of care than those with insurance, including Medicaid. These measures, however, are fairly gross indicators of access but may be sensitive to important changes in access for particular groups.

With information about the frequency of visits and hospitalizations and, to some extent, the nature of these services, it is possible to monitor, for example, emergency room and outpatient department use by Medicaid beneficiaries. Inadequate access to primary care in physicians' offices often results in emergency room use for nonurgent care. Data from the National Medical Care Utilization and Expenditure Survey showed that Medicaid beneficiaries who qualified through Aid to Families with Dependent Children (AFDC) used emergency room services and outpatient departments at much higher rates than the non-Medicaid population (HCFA/NCHS 1985). Hurley and his colleagues (1989), for example, compared the impact of four Medicaid case management programs on the use of emergency room services by AFDC populations over a period of several years. They found that managed care significantly decreased emergency room use by both adults and children.

Information describing the process of care can be gathered and compared against established standards of care. It should be possible, for instance, to identify the proportion of Medicaid patients who fail to receive expected followup care. Patients treated for urinary tract infections who have no followup urine culture or those hospitalized with acute myocardial infarctions who do not see a physician in the first month post-discharge may indicate access problems. This approach underlies many of the clinically based indicators used in the Commission's Medicare access monitoring (PPRC 1995).

Patterns of primary and specialty care could also reveal problems with continuity and coordination of care in the program. In addition, it should be possible to determine whether appropriate levels of ongoing primary care or necessary referrals for specialty care are being made for Medicaid beneficiaries with specific health problems. Hypertensive patients being treated with prescription drugs, for example, ought to have some number of evaluation visits in a year. Likewise, an insulin-dependent diabetic over 50 ought to have been referred for an evaluation by an ophthalmologist. Fewer visits or no referral might indicate access problems (Weiner et al. 1990).

Hospital Care. Because few, if any, disease-specific standards of hospital care currently exist and measures of illness severity are generally not available, it is difficult to use hospital data to determine if appropriate care is being provided to particular population groups. Broad indicators of hospital resource use, such as length of stay and hospital charges, however, have been used to compare the hospital care Medicaid beneficiaries received with that of people with private health insurance and with the uninsured (Dowd et al. 1986; Weissman and Epstein 1989). These studies concluded that more hospital resources are expended on privately insured and Medicaid patients than on uninsured patients. By contrast, Braveman and her colleagues (1991) found that Medicaid and uninsured sick newborns had significantly shorter

lengths of stay and lower total charges per day than insured newborns. Low rates of diagnostic and surgical procedures for Medicaid patients also have been reported (Wenneker et al. 1990).

These studies benefited from unique data sets containing uniform sociodemographic, diagnostic, and procedure information—elements generally not available from Medicaid claims or from encounter data. Some studies had limited ability to control for severity of illness, making it impossible to determine whether lower usage indicated underservice or whether care provided was appropriate.

Potential Baseline: Monitoring Access Using Utilization and Related Measures

The National Health Interview Survey (NHIS) 1993 Access to Care Supplement includes several questions that can be used to develop baseline estimates of some access measures for those under the poverty level.[7] In particular, the survey includes questions about respondents' usual source of care, frequency of physician visits, and whether lack of money or insurance has been a barrier to access. Additionally, a special set of questions addresses continuity of care among children, as well as satisfaction with certain aspects of that care.

Information on age and self-reported health status can be used to group respondents into gross risk categories to minimize the role of likely health status differences in the various access and utilization estimates. For example, young children and adults in poor health are likelier than healthy adults to have more physician visits. Unfortunately, these risk categories cannot be refined because of the sample size.

As expected, healthy adults under 65 years old are the least likely to report having a usual source of care (Table 19-2).[8] This is consistent with the notion that they are the least likely to perceive themselves as needing preventive or acute care services. Adults with poor health in this age group are less likely to have a usual source of care than either children or older adults, who, regardless of health status, are the most likely to have a usual source of care.

Table 19-2. Source of Care, by Risk Category, 1993 (percentage)

Risk Category	Has Usual Place and Person	Has Usual Place But Not Usual Person	Has Neither Usual Place or Person	Don't Know, Not Available
Under 18	61.9%	20.5%	11.4%	6.2%
18-64, Good to Excellent Health	45.5	20.5	27.0	7.0
18-64, Fair to Poor Health	58.5	19.0	16.6	5.8
65 and Older, Good to Excellent Health	78.4	6.8	9.3	5.5
65 and Older, Fair to Poor Health	74.9	12.1	8.9	4.1
All	56.1	19.4	18.1	6.4

SOURCE: Physician Payment Review Commission analysis of the 1993 National Health Interview Survey Access Supplement.

[7] The poverty level was used, rather than some multiple, to reduce the amount of missing data. A more detailed measure of income that could be used to create different multiples of the poverty level is missing in over 15 percent of cases. Based on more gross measures of income, a poverty indicator could be developed for about half of these missing cases.

[8] "Healthy" here refers to those who report being in excellent, very good, or good health; "poor health" indicates a report of fair to poor health.

The reported number of physician visits in the previous three months correlates more closely with health status than the usual-source-of-care measure (Table 19-3). All adults over 18 years old with poor health status are much more likely to have had three or more visits than the other groups. That children under the age of 18 are the most likely to have had no visit is somewhat surprising, given the greater emphasis on well-child care relative to the use of general preventive care services by adults and the limited Medicare coverage for preventive services. The group least likely to be eligible for Medicaid or Medicare—18 to 64 year-olds—is the most likely to report that lack of money or insurance was a barrier to receiving care in the previous year (Table 19-4).

Nearly three-quarters of those under 18 years old receive routine, preventive, and acute care services from the same source (Table 19-5). Among those under 18 with a usual source of care, the survey reports that 7

Table 19-3. Number of Physician Visits in Previous Three Months, by Risk Category, 1993 (percentage)

Risk Category	No Visits	1-2 Visits	3 or More Visits	No Source of Care for More Than 12 Months	Don't Know, Not Available
Under 18	42.5%	35.1%	7.8%	13.1%	1.4%
18-64, Good to Excellent Health	41.6	25.3	8.6	23.4	1.0
18-64, Fair to Poor Health	23.4	28.9	30.9	15.4	1.5
65 and Older, Good to Excellent Health	33.1	37.6	14.9	12.4	2.0
65 and Older, Fair to Poor Health	16.0	41.1	32.0	9.2	1.8
All	38.6	30.8	11.9	17.3	1.3

SOURCE: Physician Payment Review Commission analysis of the 1993 National Health Interview Survey Access Supplement.

Table 19-4. Lack of Money or Insurance as Access Barrier, by Risk Category, 1993 (percentage)

Risk Category	Was Lack of Money or Insurance a Reason for Not Receiving Care in Past Year? Yes	No
Under 18	2.8%	97.2%
18-64, Good to Excellent Health	5.5	94.5
18-64, Fair to Poor Health	12.9	87.1
65 and Older, Good to Excellent Health	1.4	98.6
65 and Older, Fair to Poor Health	2.5	97.5
All	5.0	95.0

SOURCE: Physician Payment Review Commission analysis of the 1993 National Health Interview Survey Access Supplement.

NOTE: "No" column includes respondents who explicitly reported that money/insurance was never a problem in obtaining needed care as well as those who reported having no problems in obtaining care.

percent are dissatisfied with the time it takes to make an appointment and 13 percent are dissatisfied with the amount of time they have to wait at the office once an appointment is made (Table 19-6).

Table 19-5. Continuity of Care Among Those under 18, 1993 (percentage)

Sources of Care for Routine, Preventive, and Acute Services	Percent of Respondents
Same Source for All Services	73.9%
Mixed Sources for Different Types of Services	3.1
No Usual Source for Any Type of Service	12.9
Don't Know, Not Available	10.2

SOURCE: Physician Payment Review Commission analysis of the 1993 National Health Interview Survey Access Supplement.

NOTE: Mixed sources of care includes those who report having a source for routine care but no source for acute care, or vice versa.

Table 19-6. Satisfaction with Usual Source of Care Among Those under 18, 1993 (percentage)

Satisfaction With:	Satisfied	Not Satisfied
Waiting Time to Make Appointment	92.7%	7.3%
Waiting Time to See Caregiver Once on Site	87.1	12.9

SOURCE: Physician Payment Review Commission analysis of the 1993 National Health Interview Survey Access Supplement.

Health Outcomes

Morbidity and mortality rates, particularly maternal and infant mortality rates, are commonly used outcomes indicators. But given that the consequences of inadequate or poor quality care may take years to become evident, these are not particularly useful measures for policy purposes. More timely measures of the outcomes of care can be created by identifying health conditions that could have been prevented had appropriate care been received as the need arose. Some such measures are included in the Commission's efforts to monitor access in Medicare (PPRC 1995).

Preventable health conditions, called sentinel health events, are an extension of the public health practice of measuring standard morbidity and mortality rates. First put forth by Rutstein and his colleagues (1976) as a means to measure quality of care, sentinel health events are defined as diseases, disabilities, and deaths that can be prevented, treated, or controlled with access to appropriate primary care. They can serve as indicators of potential unmet need, trigger investigation of underlying causes of poor access, and reveal corrective actions (Rutstein et al. 1976; HRSA 1987; Carr et al. 1988). For example, research using

sentinel events has been used to examine avoidable hospital conditions as indicators of poor access to primary care (Weissman et al. 1992; Billings et al. 1993; Bindman et al. 1995).

Three kinds of sentinel health events have been described. First, there are singular conditions that should never occur if individuals are receiving ongoing primary care, such as a detectable rate for a vaccine-preventable disease. Second are those conditions that may never be totally prevented, but whose incidence likely can be reduced, such as the incidence of low birthweight babies. The third kind of sentinel event consists of complications or later stages of a disease that occur because of uncontrolled progression of the condition, such as bleeding ulcer and diabetic ketoacidosis.[9]

Recently, there has been research and development activity pertaining to sentinel event and related indicators for the Medicaid population. HCFA has funded a study on this topic that is nearly completed. The study identifies hospital admissions that are sensitive to the use of ambulatory care or discretionary in regard to their medical necessity (Hadley and Steinberg 1993). Preliminary results indicate that those insured by Medicaid are more likely to be admitted to hospitals for conditions that are highly sensitive to ambulatory care and less likely to be admitted for highly discretionary conditions (Hadley and Steinberg 1994).[10]

Potential Baseline: Monitoring Access Using Clinically Based Measures

As an example of how some of these measures would be applied to Medicaid beneficiaries, the Commission's analysis of clinically based indicators conducted for its 1995 access report to the Congress was repeated to compare those Medicare beneficiaries with some type of Medicaid coverage with those who have no Medicaid coverage.[11] Medicare enrollment records were used to identify those beneficiaries who were covered by a Medicaid buy-in agreement at any point during 1992 and 1993. An analysis of 1992 and 1993 Medicare claims data was then conducted in a manner identical to the one described in the Commission's report on monitoring access (PPRC 1995). All estimates are age-sex adjusted. These indicators include a mix of utilization and outcomes measures.

Statistically significant differences between indicator rates for the Medicaid and non-Medicaid groups were found for 25 indicators, half of which exceeded 10 percent (Table 19-7). For the most part, these differences suggest that the Medicare beneficiaries covered by buy-in agreements were much less likely to receive specific types of followup care or testing. For example, although the rate at which non-Medicaid beneficiaries received an electrocardiogram within three months of an initial diagnosis of congestive heart failure was fairly low at 40 percent, it was significantly higher than the 32 percent rate for Medicaid

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[9] Such conditions almost always require hospitalization and therefore hospital discharge data are particularly well-suited for analysis of these events. Incidence and prevalence rates among at-risk populations can be compared with average population rates to determine relative risks and potential access problems.

[10] Other policy analysts have used this approach to monitor access in the Massachusetts Medicaid program (Schwartz and Porter 1995).

[11] Most Medicare beneficiaries without Medicaid coverage have some form of supplemental insurance, either provided by a previous employer or purchased individually. Such supplemental insurance covers at least Medicare copayments. See Chapter 16 for a discussion of these policies.

Table 19-7. Clinically Based Indicators of Access to Care for the Elderly, by Medicaid Buy-In Status (proportion of patients receiving care and number of patients with disease or condition)

Indicator	Total	Medicaid Buy-In 1992-93 Yes		Medicaid Buy-In 1992-93 No
Heart and Circulatory System				
Visit within 4 weeks following discharge of patients hospitalized for myocardial infarction (MI)	0.842 2487	0.837 271		0.845 2216
Cholesterol test once every 6 months for patients hospitalized for MI who have hypercholesterolemia	0.780 533	0.846 41		0.779 492
Electrocardiogram (EKG) during emergency room (ER) visit for unstable angina	0.815 3292	0.817 514		0.815 2778
Visit within 4 weeks following discharge of patients hospitalized for unstable angina	0.803 3426	0.783 476		0.807 2950
Visit every 6 months for patients with chronic stable angina	0.957 21431	0.971 2959	*	0.955 18472
Followup visit or hospitalization within 1 week of initial diagnosis of unstable angina	0.868 2930	0.872 353		0.866 2577
Lipid profile in the first year after initial diagnosis of angina	0.512 8066	0.470 989	*	0.518 7077
Chest X-ray within 3 months of initial diagnosis of congestive heart failure (CHF)	0.704 15899	0.704 2758		0.705 13141
Visit within 4 weeks following discharge of patients hospitalized for CHF	0.845 5223	0.780 850	*	0.853 4373
Visit every 6 months for patients with CHF	0.955 33825	0.958 6910		0.954 26915
EKG within 3 months of initial diagnosis of CHF	0.385 15899	0.322 2758	#	0.398 13141
Visit within 4 weeks following discharge of patients hospitalized with malignant or otherwise severe hypertension	0.825 275	0.634 50	#	0.862 225
Among patients with known angina: 3 or more ER visits for cardiovascular-related diagnoses in 1 year	0.034 33659	0.072 4910	#	0.029 28749
Nonelective admission for congestive heart failure	0.026 340509	0.040 37964	#	0.024 302545
Stroke				
EKG within 2 days of initial diagnosis of transient ischemic attack (TIA)	0.360 4819	0.339 667		0.364 4152
For TIA patients with eventual carotid endarterectomy: interval between carotid imaging and carotid endarterectomy less than 2 months	0.627 536	0.718 48		0.619 488
Visit within 4 weeks following discharge of patients hospitalized for TIA	0.796 1410	0.725 184	#	0.807 1226

Table 19-7. (continued)

Indicator	Total	Medicaid Buy-In 1992-93 Yes		No
Visit every year for patients with diagnosis of TIA	0.982 6595	0.988 1066		0.981 5529
For patients hospitalized for carotid territory stroke: carotid imaging within 2 weeks of initial diagnosis	0.697 1032	0.725 91		0.700 941
For cerebrovascular accident (CVA) patients with eventual carotid endarterectomy: interval between carotid imaging and carotid endarterectomy less than 2 months	0.563 1095	0.493 87		0.563 1008
Visit within 4 weeks following discharge of patients hospitalized for CVA	0.740 3040	0.748 380		0.743 2660
Pulmonary				
Visit every 6 months for patients with chronic obstructive pulmonary disease (COPD)	0.931 35532	0.951 5580	*	0.926 29952
Among patient with pneumonia: diagnosis of lung abscess or empyema	0.009 33520	0.007 6853	#	0.010 26667
Among patients with known chronic bronchitis: subsequent admission for respiratory diagnosis	0.564 8677	0.641 1547	#	0.550 7130
Among patients with known emphysema: subsequent admission for respiratory diagnosis	0.589 6527	0.641 995	*	0.579 5532
Among patients with known COPD: subsequent admission for respiratory diagnosis	0.545 29917	0.608 5136	#	0.534 24781
Breast Cancer				
For patients with breast cancer and eventual mastectomy: interval from biopsy to definitive therapy (surgery delay time) should be less than 3 months	0.645 989	0.589 129		0.656 860
Visit every 6 months for breast cancer patients who have undergone mastectomy and cytotoxic chemotherapy	1.000 114	1.000 12		1.000 102
Mammography every year for patients with a history of breast cancer	0.609 4844	0.517 442	#	0.619 4402
At initial diagnosis of breast cancer: mammogram	0.644 1886	0.566 199	#	0.655 1687
At initial diagnosis of breast cancer: chest X-ray	0.658 1886	0.745 199	#	0.650 1687
Visit every year for breast cancer patients who have undergone mastectomy without cytotoxic chemotherapy	0.846 1275	0.869 156		0.844 1119
Mammography every 2 years in female patients	0.386 104433	0.266 11526	#	0.402 92907
Diabetes				
Glycosylated hemoglobin or fructosamine every 6 months for patients with diabetes	0.260 54159	0.216 9743	#	0.269 44416

Table 19-7. (continued)

Indicator	Total	Medicaid Buy-In 1992-93 Yes		No
Eye exam every year for patients with diabetes	0.382 36814	0.327 6352	#	0.393 30462
Visit within 4 weeks following discharge of patients hospitalized for diabetes	0.805 1059	0.810 230		0.810 829
Visit every 6 months for patients with diabetes	0.931 44335	0.950 7571	*	0.928 36764
Among patients with known diabetes: admission for hyperosmolar or ketotic coma	0.005 26178	0.006 5209		0.005 20969
Gastrointestinal Bleeding				
Visit within 4 weeks following discharge of patients hospitalized for gastrointestinal bleed	0.789 1793	0.702 264	#	0.805 1529
Hematocrit within 4 weeks following discharge of patients hospitalized for gastrointestinal bleed	0.616 1793	0.526 264	#	0.629 1529
Followup visit within 4 weeks of initial diagnosis of gastrointestinal bleed	0.823 6362	0.835 803		0.823 5559
Anemia				
For patients with iron deficiency anemia: gastrointestinal workup	0.389 5409	0.359 943		0.393 4466
Hematocrit/hemoglobin between 1 and 6 months following initial diagnosis of anemia	0.454 11596	0.479 1821	*	0.450 9775
Other				
Cholecystectomy (open or laparoscopic) for patients with cholelithiasis and 1 or more of the following: cholecystitis, cholangitis, gallstone pancreatitis	0.405 3643	0.354 535	#	0.412 3108
Visit within 2 weeks following discharge of patients hospitalized for depression	0.950 812	0.970 126		0.944 686
Arthroplasty or internal fixation of hip during hospital stay for hip fracture	0.857 4346	0.841 894		0.861 3452
Among patients with known cholelithiasis: diagnosis of perforated gallbladder	0.004 9331	0.004 1470		0.004 7861
Visit every year	0.769 340509	0.866 37964	#	0.757 302545
Assessment of visual impairment every 2 years	0.380 340509	0.337 37964	#	0.386 302545

SOURCE: Physician Payment Review Commission analysis of 1992-1993 Medicare claims, 1 percent sample of beneficiaries.

* significant difference at 5 percent level.
# significant difference at 5 percent level, difference greater than 10 percent.

beneficiaries. Similarly, the Medicaid group was likelier to exhibit patterns of care thought to be related to inadequate disease management, such as three or more emergency department visits within a year for cardiovascular-related diagnoses.

The Medicaid group appears to fare quite well using certain indicators that measure a followup visit within six or more months of a particular event. These are relatively nonspecific measures, since the visit was not necessarily a followup to the associated event; any office or nursing home visit was regarded as a possible indicator of the appropriate followup care. These indicators, therefore, may reflect relatively high numbers of visits for the Medicaid group, consistent with the fact that it includes comparatively sicker beneficiaries and a larger share of nursing home residents, who legally must receive at least one visit every six months. It seems likely that these factors are indeed affecting the indicator rates, because the Medicaid group fares relatively worse when visits are required within shorter windows, such as within four weeks after discharge with malignant or otherwise severe hypertension (63 percent for Medicaid versus 86 percent for all other Medicare beneficiaries). Without more sophisticated analyses or risk adjustment, these nonspecific measures of utilization should be interpreted cautiously.

Because the Medicaid group is generally poorer and sicker than the rest of the Medicare population, both the prevalence of some conditions underlying the indicators and care-seeking behavior may differ between the groups. Rather than serving as the basis for an in-depth analysis of differences between current beneficiary groups, these estimates could be a baseline for subsequent analyses of the utilization and outcomes of those Medicare beneficiaries also covered by Medicaid to detect changes in access.

DATA NEEDS AND AVAILABILITY

In monitoring access of Medicaid beneficiaries, the various types of measures discussed above can be developed from four sources of data: claims, encounters, hospital discharge abstracts, and surveys. Currently, very limited comprehensive data exist about Medicaid beneficiaries and their health care utilization, and some of these sources may be eliminated or trimmed with implementation of a Medicaid block grant program. There are more extensive data for Medicare beneficiaries who have buy-in coverage, but even these data are limited for beneficiaries in managed-care organizations. In general, different types of information will be available for different groups of people, depending on whether they are covered and what type of coverage they have (e.g., fee for service, managed care). Those without Medicaid may be included only in survey data and hospital discharge abstracts, while those in a fee-for-service program will be represented in claims, discharge abstracts, and survey data. Similarly, if states adopt a direct-service model for their Medicaid programs, then all-payer hospital discharge abstracts and surveys may become principal sources for across-state analyses of access.

Claims Data

Medicaid claims data suitable for monitoring access are very limited compared to those available for Medicare.[12] Unlike Medicare, Medicaid does not have a standardized national claims data system.

[12] Although Medicare data files are more uniform than Medicaid's, Medicaid data capture more information on health services because the Medicaid benefit package is broader than Medicare's. Again, however, the value of claims data will be diminished as more beneficiaries shift into managed care.

Medicare as a Model. Before discussing Medicaid claims files, it is useful to review the development of Medicare physician claims data as a model. Before the mid-1980s, each of 56 Medicare carriers had its own data system and coding conventions. Since then, Medicare has gradually developed a national system, first with the Part B Medicare Annual Data (BMAD) system, and now with the National Claims History System. Since 1985 HCFA has required the use of Current Procedural Terminology (CPT) codes for most physicians' services, and has standardized the use of specialty, type of service, place of service, and modifier codes. HCFA also has used edit checks to maintain the internal consistency of these data files. With the implementation of the Medicare Fee Schedule, the final standardization of Medicare data was achieved by eliminating most local procedure codes and nationalizing payment policies. Data for other provider sectors are also available through the National Claims History System.

In addition to standardizing data elements, Medicare claims data are available in a relatively timely fashion. Under the National Claims History System, claims can be monitored on a flow basis, if desired. A denominator file also has been developed that includes information on beneficiary eligibility, residence, and limited sociodemographic characteristics. This file makes it possible to compare utilization rates across subgroups of Medicare beneficiaries.

Medicaid Files. By contrast, the national Medicaid data files have significant limitations. All national Medicaid files are based on information maintained in each state's Medicaid Management Information System (MMIS) and are limited by allowed variation in MMIS data.[13] MMIS specifies performance standards for processing claims, collecting information on providers and beneficiaries, furnishing data for statistical purposes, and identifying fraud and abuse (CRS 1988). These standards do not require uniformity of data across the states, however.

There have been some efforts to develop comparable, nationwide Medicaid data. The voluntary Medicaid Statistical Information System (MSIS) contains claims and eligibility data similar to BMAD and the Medicare denominator file. The primary-level MSIS files include both eligibility and claims files. The eligibility file includes a beneficiary identifier; demographic data (e.g., birth date, sex, race); ZIP code; basis of eligibility; and days of enrollment. There are separate files for inpatient hospital, long-term care facilities, and other services such as physicians' services and prescription drugs. Fields include beneficiary identifiers, payments, diagnosis codes, and service codes. The secondary-level MSIS file is a person-level file that summarizes each individual's eligibility information and claims for the year. States can submit MSIS data in lieu of certain other reporting requirements.

The MSIS files have three limitations. Because participation is voluntary, only 26 states, accounting for about 40 percent of Medicaid expenditures, submit claims and eligibility data to HCFA. Second, states are

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[13] In 1980 the Congress required development of MMIS in all but the smallest states. Although Alaska, Delaware, Nevada, Rhode Island, and Wyoming are exempt from this provision, Alaska and Wyoming have implemented MMIS, and the remaining states have systems to process claims and review utilization. Alaska, Delaware, Nevada, and Wyoming submit data for the Medicare Statistical Information System.

The Tape-to-Tape project, a long-running pilot activity of HCFA's Office of Research and Demonstrations, includes high-quality Medicaid claims data for four states: California, Georgia, Michigan, and Tennessee. HCFA's contractor has reprocessed MMIS data to create research-useable enrollment, provider, and claims files for these states, crosswalking state-specific codes to standardized codes and reconciling original and adjusted claims records to create one claim record for each service. The Tape-to-Tape project has produced data of such good quality that they have been used for a variety of analyses and published articles.

HCFA is now developing State Medicaid Research Files (SMRFs), which are based on MSIS and the Tape-to-Tape data project. The SMRF undertaking will use the experience of the Tape-to-Tape project to develop four high-quality Medicaid claims files (inpatient, long-term care, prescribed drugs, and other) and an enrollment file.

The 26 states that participate in MSIS and 2 others will participate in SMRF. HCFA plans to complete 1992 files for 16 of these states by early 1996. Files will be created for selected earlier years depending on the status of the state participation. Data for Tape-to-Tape states will be processed starting with 1985 files; data from 13 other states will be processed starting with 1988 files; and data from all other participating states will be processed starting with 1990 files.

Currently, it is impossible to measure access, quality, and other related dimensions for Medicaid beneficiaries in all states from claims data. HCFA collected data from just 4 states for the Tape-to-Tape project, only 26 states participated in MSIS, and 28 are participating in SMRF. If block grants are adopted, the incentive to participate that comes from the waiving of other reporting requirements may be greatly diminished so that the status of these projects would be unclear. In the extreme case, the only consistent, national claims data available about Medicaid beneficiaries would be for the dual-eligible beneficiaries served by fee-for-service Medicare.

Encounter Data

Given the growing importance of managed care under Medicaid, claims-based measures will be relevant for a smaller and smaller portion of service use. Encounter data will likely be needed to monitor access in the managed-care sector.

Early experience with the collection of encounter data for Medicare and Medicaid beneficiaries has been disappointing. Of the 30 health maintenance organizations that participated in a Medicare risk-contracting demonstration between 1980 and 1985, only 2 could provide even partial encounter data (Langwell and Hadley 1990). Eight years after the creation of Arizona's Medicaid program, only half of the managed-care organizations could satisfy HCFA's standards for encounter data (McCall et al. 1993).

Recent developments suggest that encounter data may become more widely available and comparable. Advances in the private sector, such as the development of the Health Plan Employer Data and Information Set, have raised stakeholders' expectations for these types of data and laid the groundwork for their wider use.[14]

[14] See Chapter 6 for information on the Health Plan Employer Data and Information Set.

There have also been changes in the public sector concerning encounter data. In April 1994 HCFA began to develop McData, a Medicare-Medicaid common data set initiative for managed-care plans. As a first step, HCFA has identified those elements of an encounter data set that would support the monitoring of access and utilization, as well as quality assurance and improvement efforts (HCFA 1995). These elements include many of those that appear on claims data, procedure, place of service, and diagnosis codes among them. Some states have collected encounter data, but most have not. Moreover, some states lack the additional resources needed to analyze the encounter data that they request.

Hospital Discharge Abstracts

Hospital discharge abstracts are one source of information about sentinel health events and utilization of hospital services. Typically, these abstracts contain patient demographic information, clinical information, procedure codes, primary and secondary payer, length of stay, and discharge status. Information from hospital abstracts can be linked to hospital-level and county-level data.

Currently, there are several limitations to the use of hospital discharge abstracts for monitoring access for Medicaid beneficiaries. Only 20 states collect standardized discharge abstracts. While these states gather many similar data elements, their layouts and field lengths differ. Editing is necessary to create a comparable data set. Finally, states collect data from different types of hospitals (some from all non-federal hospitals and others from general community hospitals, for instance) and on different types of patients (for example, some states do not collect data on self-pay or charity patients). The availability of comparable, all-payer, discharge hospital data would support some analyses of access across-care delivery models, including direct-service models.

Survey Data

Differences in claims and encounter data across states and delivery systems may limit the ability to support comprehensive analyses of access for Medicaid beneficiaries. Hospital discharge data, if more widely available, could only be used to estimate certain types of access measures. Therefore, survey data may provide an important complement to these other types of data. With surveys, access could be monitored at the state or national level and through a variety of measures.

Current Surveys. In its 1993 annual report, the Commission looked at four major surveys whose scope, focus, and timeliness could be used to monitor access for Medicaid beneficiaries not covered by Medicare: the National Health Interview Survey; the National Maternal and Infant Health Survey of 1988 (NMIHS) and its 1991 longitudinal followup; the Survey of Income and Program Participation (SIPP); and the National Medical Expenditure Survey of 1987 (NMES).

NHIS appears to be superior to the other surveys for the purpose of monitoring access for Medicaid beneficiaries. It is conducted annually unlike NMES and NMIHS. Its sample size is more than twice that of the other surveys. Since the NHIS covers health issues like utilization, sociodemographic characteristics, and health and functional status measures, its content is more appropriate for measuring access (PPRC 1993a).

The Commission found that none of these surveys has a large enough sample to provide either aggregate estimates for all states or reliable state-level estimates for subgroups of interest, such as pregnant women or children under the age of six. NHIS, the largest of the four surveys, would produce an effective national sample size of 7,000 to 8,000 Medicaid beneficiaries.[15] At best, it is expected that it would have effective Medicaid samples of about 900 in California, 600 in Texas, 500 in New York, and 300 to 350 in 15 or so other states.[16] Thus, NHIS could not be used to produce estimates for most states or for state-level estimates for most subgroups of Medicaid beneficiaries. Further, while national and regional estimates for some of the subgroups may be available using NHIS, data definition and completeness may limit the survey's usefulness. For example, because income is missing for about 15 percent of respondents in the 1993 insurance supplement, the usefulness of this survey will be somewhat limited in analyzing insurance status for those under a specified percentage of the poverty level.

Other smaller surveys may provide enough information for analysis of certain subgroups. NMIHS, for example, could be used for national or regional estimates of measures for pregnant women. SIPP could be used for estimates in the most populous 5 to 10 states and for some subgroups, while NMES could support some subgroup analysis at the national level (Hadley et al. 1993).

In addition to these four surveys, the Medicare Current Beneficiary Survey could be used to monitor access of dually eligible beneficiaries. CBS is a survey of about 12,000 beneficiaries sponsored by HCFA's Office of the Actuary. The survey and its supplements contain information on access, utilization of services, expenditures, health insurance coverage, health status, and physical functioning as well as demographic data. The access supplement survey is conducted yearly. CBS was constructed to be representative of the Medicare population as a whole. The oldest-old and the disabled beneficiaries under 65 were oversampled to support analyses of these populations. To maintain the longitudinal panel, additional beneficiaries are added to replace those no longer in the sample due to death, emigration, or refusal to participate.

Monitoring Access at the National Level. A survey-based monitoring strategy could be developed that would analyze changes at the national level. Because of their timeliness and content, NHIS and CBS are available instruments that could be used for national monitoring. While this approach could be the first step toward monitoring access in Medicaid nationwide, it ultimately may not be sufficient because of expected policy differences across the states and for specific subgroups.

Monitoring Access at the State Level. The Commission recommended in its 1994 annual report that HCFA periodically survey Medicaid beneficiaries in all states. Under contract with the Commission, the Center for Health Policy Studies at Georgetown University and Mathematica Policy Research developed such a survey, primarily using items from NHIS (Gold et al. 1995; Eisenhower et al. 1993; Eisenhower et al. 1994). A pilot test of the survey was also carried out, demonstrating the adequacy of the instrument, the

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[15] The effective sample size is the number of observations from a simple random sample that would produce the same standard error as the complex sample.

[16] In addition to the problems of sample size, there is a danger that the geographic clusters sampled might not be representative of the state, such as an urban community in a predominantly rural state.

appropriateness of Medicaid eligibility files as a sampling frame, and the feasibility of developing comparisons from NHIS.

Such a survey would cost between $6 million and $12 million, depending upon its design. This amount would cover telephone and in-person interviews with 30,000 to 45,000 beneficiaries, permitting access to care for each state's Medicaid population to be compared with access for those with private insurance, as measured by a national survey like NHIS.[17]

NEXT STEPS IN DEVELOPING A MEDICAID ACCESS MONITORING SYSTEM

Any assessment of the Medicaid program—either in its current form or after it has undergone restructuring—will require more systematic information about enrolled and eligible populations' access to care. Such a system will help stakeholders understand whether the program is meeting its goals and provide policymakers with information about how to improve the program. As the Commission has previously noted, the most important step in creating such a monitoring system for Medicaid beneficiaries is the development of appropriate data resources. Since each type of data—claims, encounters, hospital discharge abstracts, and surveys—has strengths and weaknesses, a variety of data sources needs to be used to monitor access comprehensively. A realistic plan should include a short-term approach built around currently available information and a longer-term plan for developing more comparable, systematic information about enrollees and eligibles across states and programs.

At present, only limited data are available, as noted earlier. To be most useful, information not only must be available in a timely fashion and contain standardized elements, but also must be capable of yielding state-specific estimates of access for all states. None of today's data sets—claims, encounters, hospital discharge abstracts, and surveys—meets all of these criteria, but they will have to suffice during the initial phase of monitoring. As a result of data limitations, these early efforts will be somewhat fragmented and incomplete.

Monitoring access using existing national surveys like CBS and NHIS is a first step toward creating national insight into access. Examples of analysis using these surveys have been presented in this chapter. Yet this approach is only a first step, since such monitoring ultimately may not be sufficient because of likely policy differences across the states. Surveys, however, can be used to establish benchmarks for certain measures, as illustrated above.

To remedy this shortcoming, the use of existing surveys could be followed by the development of a national survey of Medicaid beneficiaries that would produce state-specific estimates of access. Such a survey could ensure that comparable measures are being collected across states. If the survey instrument used questions from other major national surveys, benchmarks would exist for comparison groups.

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[17] A sample size of 30,500 would allow 530 observations per state plus 4,000 additional observations for the eight largest states. Given design effects such as those due to clustering, this would allow a 95 percent confidence interval of plus or minus 5 percentage points.

Since surveys lack precision in generating utilization and clinically based estimates, they would need to be supplemented by claims and encounter data. To do this, HCFA would have to require or offer incentives for states to provide such data. The SMRF project and McData would be a fitting starting point for this effort. In the long term, such efforts, if inclusive of all states, could create a rich resource for monitoring access and improving the Medicaid program.

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JOSEPH P. NEWHOUSE, Ph.D., is the John D. MacArthur Professor of Health Policy and Management at Harvard University, with appointments on the faculties of the John F. Kennedy School of Government, the Harvard Medical School, the Harvard School of Public Health, and the Faculty of Arts and Sciences. He was the founder and editor of the *Journal of Health Economics* and an associate editor of the *Journal of Economic Perspectives*. Dr. Newhouse is a past president of the Association for Health Services Research. A member of the Institute of Medicine of the National Academy of Sciences, he serves on its governing council and executive committee. He is also a member of the American Academy of Arts and Sciences. Dr. Newhouse was at RAND for 20 years, where he was the principal investigator for the RAND Health Insurance Experiment. He has received the Distinguished Investigator Award from the Association for Health Services Research, the David N. Kershaw Award and Prize from the Association for Public Policy and Management, the Baxter American Foundation Prize, the Hans Sigrist Prize, the Elizur Wright Prize, and the Administrator's Citation from the administrator of the Health Care Financing Administration. He received a doctorate in economics from Harvard University.

MARK V. PAULY, Ph.D., is vice dean of the Wharton Doctoral Program and Bendheim Professor. He is professor of health care systems, insurance and risk management, and public policy and management at the Wharton School, and professor of economics in the School of Arts and Sciences at the University of Pennsylvania. He served as executive director of the Leonard Davis Institute of Health Economics from 1984 to 1989 and as director of research from 1989 to 1995. Dr. Pauly is a member of the Institute of Medicine of the National Academy of Sciences, and adjunct scholar of the American Enterprise Institute. He has been a member of the technical advisory panels to the National Institute of Drug Abuse, the Health Care Financing Administration's Division of National Cost Estimates, and the Advisory Council on Social Security. He has been on the editorial boards of the *Journal of Health Economics*, the *Public Finance Quarterly*, and several other professional journals. Dr. Pauly has published more than 100 journal articles and books in the fields of health economics, public finance, and health insurance. He received a master's degree from the University of Delaware and a doctorate in economics from the University of Virginia.

EARL P. STEINBERG, M.D., M.P.P., is vice president of Health Technology Associates, Inc. (HTA) and co-director of HTA's Outcomes Studies Group. Dr. Steinberg is also a professor of medicine at Johns Hopkins University School of Medicine, and has a joint faculty appointment in the Department of Health Policy and Management of the Johns Hopkins School of Hygiene and Public Health. He currently serves as a member of the national Blue Cross Blue Shield Association's medical advisory panel. His research focuses on technology assessment, the cost and effectiveness of alternative patterns of medical practice, methods for evaluating the quality of care, and the clinical and economic impacts of health care payment innovations. His work at HTA focuses on design, implementation, and management of outcomes and quality assessment systems for providers and the development of tools that promote cost-effective care. Dr. Steinberg was the principal investigator on the federally funded Patient Outcome Research Team devoted to evaluating variation in management of cataracts and their relationship to patient outcomes. He currently

oversees the design and implementation of a national outcomes database for the American Academy of Ophthalmology. Dr. Steinberg has received numerous awards, including the Henry J. Kaiser Family Foundation Faculty Scholar Award in General Internal Medicine and the Outstanding Young Investigator Award from the Association for Health Services Research. Dr. Steinberg received a bachelor's degree from Harvard College, a medical degree from Harvard Medical School, and a master's of public policy from the Kennedy School of Government. He completed a residency in internal medicine at Massachusetts General Hospital.

RAY E. STOWERS, D.O., is an osteopathic family physician who has been in solo primary care medical practice in the rural, underserved community of Medford, Oklahoma, since 1974. Dr. Stowers has been a member of the American Medical Association's Relative Value Scale Update Committee since 1992. He currently chairs the Advisory Council of the Department of Family Medicine at the Oklahoma State University College of Osteopathic Medicine, where he serves as an adjunct professor and designed the preventive medicine curriculum. Dr. Stowers also chairs the governance committee of the Oklahoma Physician Manpower Training Commission and is a member of the American Osteopathic Association's Council on Federal Health Programs. He is a fellow of the American College of Family Practice in Osteopathic Medicine and Surgery, and former president of the Oklahoma Osteopathic Association. He has also served on numerous professional councils and task forces. Dr. Stowers received a degree in osteopathic medicine from the University of Health Sciences, College of Osteopathic Medicine in Kansas City, Missouri.

ROGER S. TAYLOR, M.D., M.P.A., is executive vice president and chief medical officer of PacifiCare Health Systems, Inc., a multiregional managed-care organization. Dr. Taylor has more than two decades of health care management experience, including the development and administration of every form of managed-health care product available today. He previously served as national leader for health care of the Wyatt Company; senior vice president, EQUICOR, Inc.; president, Corporate Health Care Management; senior vice president and co-founder, United Medical Plans, Inc.; and regional medical director, CIGNA Health Plans of California. Dr. Taylor has served in a number of other policy-related roles, including president and co-founder of the Utilization Review Accreditation Commission; commissioner, California Health Facilities Commission; and director of California's Emergency Medical Services Authority. He is a well-known speaker and writer on health care issues and has consulted internationally on health reform. Dr. Taylor received a medical degree from the University of Southern California School of Medicine and a master's degree in public administration from the University of Southern California School of Public Administration.

Commission Staff

LAUREN B. LeROY, Ph.D., is executive director. She served as acting executive director during 1995 and as deputy director since the Commission's inception in 1986. Before coming to the Commission, Dr. LeRoy was associate director of the Commonwealth Fund Commission on Elderly People Living Alone. She spent 12 years at the Institute for Health Policy Studies, University of California, San Francisco, where she was assistant director and then director of the Institute's Washington office. She was also an analyst working on health issues in the Department of Health and Human Services (formerly Health, Education, and Welfare). Dr. LeRoy's research interests and published work have focused on physician payment reform, physician training and practice, the nurse labor market, and health care for the elderly. She is a member of the National Academy of Social Insurance and serves on the editorial board of the Association for Health Services Research's Health Administration Press. She received a doctorate in social policy planning from the University of California, Berkeley.

DAVID C. COLBY, Ph.D., is deputy director. Before joining the Commission in 1988, he held faculty and administrative positions at Williams College and the University of Maryland, Baltimore County. From 1986 to 1987, he was a Robert Wood Johnson health finance fellow. His current work at the Commission involves access to care, quality of care, and Medicaid issues. Dr. Colby's published research has focused on Medicaid and Medicare, AIDS politics and policies, and various topics in political science. He is an associate editor of the *Journal of Health Politics, Policy and Law*. He received his doctorate in political science from the University of Illinois.

DON COX, Ph.D., is a senior analyst. Before joining the Commission, Dr. Cox was a senior economist at the Federal Trade Commission and Fu Associates, Ltd. In addition, he has worked in the Occupational Safety and Health Administration and the Department of Defense. His work at the Commission has involved application of antitrust laws to physician networks, competitive bidding, analysis of the effect of Medicare payment policies on physicians and private payers, and risk selection and adjustment. He received a doctorate in economics from the University of Maryland.

CHRISTINE CUSHMAN is an analyst. Her work at the Commission focuses on analyses of Medicare expenditure data and issues relating to broadening choices for Medicare beneficiaries, including enrollment, disenrollment, and marketing policies. She received a master's degree in public policy from Georgetown University.

ELIZABETH DOCTEUR is an analyst. She previously worked at Strong Memorial Hospital in Rochester, New York, where she also completed an internship in the Office of Strategic Planning. Her recent work at the Commission has focused on standards for health plans that serve Medicare beneficiaries, and on approaches for monitoring access to care and for promoting quality in Medicare managed care. She received a master's degree in public policy analysis from the University of Rochester.

DONNA O. FARLEY, Ph.D., is a senior analyst. Before joining the Commission, she worked on RAND Medicare payment policy studies relating to hospital outlier payments and capitation payment for the end stage renal disease program. She brings more than 15 years of health care management experience to her health policy work, most recently serving as senior vice president for planning and business development for a regional system of Catholic hospitals based in the Chicago area. Her work at the Commission involves issues related to Medicare capitation payment policy, risk program enrollment, and rural delivery systems. She received a doctorate in public policy from the RAND Graduate School.

LORI GRUBER is an analyst. Previously, she worked as a statistician at the Center for International Research of the Bureau of the Census. Her work at the Commission focuses on the financial liability of Medicare beneficiaries, methods for managing Medicare's fee-for-service program, and the effects of secondary insurance on service use. She received a master's degree in public policy and management from Carnegie Mellon University.

KEVIN HAYES, Ph.D., is a senior analyst. He has worked as a health care planner for a local planning agency and a public hospital system. His work at the Commission focuses on monitoring Medicare beneficiaries' access to care and analysis of claims data to measure changes in payment rates and service utilization. He received a doctorate in health policy and administration from the University of North Carolina at Chapel Hill.

ANNETTE HENNESSEY is the executive assistant. Before joining the Commission, she worked for Senator Bill Bradley, where she was primarily responsible for administration of the legislative staff. As assistant to the executive and deputy directors, she assists in managing Commission operations. She received a bachelor's degree in political science from Mississippi State University in Starkville.

SARAH C. HESPENHEIDE is a junior analyst. Previously, she served for two years on the Commission's administrative staff. At the Commission, her work focuses on issues relating to secondary insurance for Medicare beneficiaries. She will earn her master's degree in health policy from the Johns Hopkins University School of Hygiene and Public Health in May.

JOHN F. HOADLEY, Ph.D., is a principal policy analyst. Before joining the Commission, he taught political science at Duke University, was a congressional fellow and legislative assistant for Representative Barbara B. Kennelly, and developed educational sessions for policymakers at George Washington University's National Health Policy Forum. At the Commission, Dr. Hoadley's work has centered on managed care, health system reform, data systems, the Medicare Fee Schedule, risk adjustment, global budgets, and beneficiary perspectives on Medicare reform. He received a doctorate in political science from the University of North Carolina at Chapel Hill.

CHRISTOPHER HOGAN, Ph.D., is a principal policy analyst. His work at the Commission has focused on the Medicare Volume Performance Standard System and Medicare beneficiaries' access to care. During the past year, he conducted analysis of private insurers' fees, areas of poor access to care, and medical savings accounts. He has also worked on such issues as risk adjustment, improving the performance of traditional fee-for-service Medicare, and Medicare beneficiaries' secondary insurance. He holds a doctorate in economics from Northwestern University.

SHERAN ESTES McMANUS is the administrative officer. She has more than 15 years of experience in program administration and management, primarily in programs with a health policy focus. She was previously executive associate of the George Washington University's National Health Policy Forum and served in various capacities at the Department of Health and Human Services (formerly Health, Education and Welfare). At the Commission, she is responsible for financial management and administration, computer network operations, and oversees the production of Commission publications. She received a bachelor's degree from the University of Maryland and continued studies at the George Washington University.

KATIE MERRELL is a senior analyst. Before joining the Commission staff, she worked for Abt Associates in the areas of health economics research, income support, and education. She was also a research assistant for the board of governors of the Federal Reserve System, and a high school mathematics and computer

science teacher. Her work at the Commission has been on practice expense, geographic adjustment of the Medicare Fee Schedule, simulating the effect of policy changes on fee schedule payments, and other issues, including the structure of the health insurance market and community rating. She spends a portion of her time at the Center for Health Administration Studies, University of Chicago.

ANNE L. SCHWARTZ, Ph.D., is special assistant to the executive director. Since joining the Commission staff, her analytical work has addressed a range of Medicare and Medicaid issues, including graduate medical education financing, physician payment and access under Medicaid, and financial protection for Medicare beneficiaries. Most recently, she has focused on the changing labor market for physicians and the effects of the evolving health care market on the Medicare program. Previously, she held various positions as a staff member in the U.S. House of Representatives. She received a doctorate in health policy from the Johns Hopkins University.

DAVID W. SHAPIRO, M.D., J.D., is a senior analyst. After completing a residency in primary care internal medicine, he was a Veterans Administration/Robert Wood Johnson Clinical Scholar. At the Commission, he has worked on Medicare coverage decisions and the appeals process, medical liability reform, and the Medicare Fee Schedule. Dr. Shapiro spends a part of his time at San Francisco General Hospital, where he is an assistant clinical professor of medicine. He received a medical degree from the University of California, Los Angeles, and a law degree from Yale.

SALLY TRUDE, Ph.D., is a senior analyst. Before joining the Commission staff, Dr. Trude was an associate policy analyst at RAND working on physician payment issues. Her current work at the Commission focuses on the impact of the Medicare Fee Schedule on physicians and beneficiaries and on the Medicare Volume Performance Standard system. She received a doctorate in public policy analysis from the RAND Graduate School.

Commission Responsibilities Mandated by the Congress

The Physician Payment Review Commission was established by the Congress through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272). It was charged with advising and making recommendations to the Congress on methods to reform payment to physicians under the Medicare program. Recommendations were to be submitted to the Congress no later than March 1 of each year, which was later amended to March 31 by the Omnibus Budget Reconciliation Act of 1987 (OBRA87, P.L. 100-203).

The legislation identified eight specific areas that the Commission should address in its recommendations to the Congress. These included the feasibility of reducing specialty and geographic differences in physician payments, increasing physician participation in Medicare's Participating Physician and Supplier Program, determining the feasibility of using physician diagnosis-related groups, and identifying the appropriate use of assistants-at-surgery. The legislation also required that the Commission advise and make recommendations to the Secretary of Health and Human Services (HHS) regarding the development of a resource-based relative value scale for physicians' services.

In the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647), the Congress further directed that the Commission consider policies for moderating the rate of increase in physicians' expenditures and utilization of physicians' services.

With the passage of physician payment reform legislation in OBRA89, the Commission was assigned the following new responsibilities: advising the Congress on setting standards for expenditure growth and updating fees; commenting on reports by the Secretary on issues related to utilization, access, and assignment policy; and conducting a series of mandated studies.

These studies included payment for practice expenses, geographic payment areas, payment for nonphysician practitioners, physician payment under Medicaid, and payment for assistants-at-surgery.

The Congress further revised the Commission's responsibilities as part of OBRA90. It repealed the requirements relating to the development of the relative value scale, while expanding the Commission's responsibilities in other areas. OBRA90 requires that the Commission consider a wide range of policies, including:

- major issues in implementation of the Medicare Fee Schedule;
- further development of the Volume Performance Standard system, including development of state-based programs;
- payment incentives to increase access to primary care and other services in inner-city and rural areas, including federal policies regarding the level of Medicaid payments to physicians;
- the supply and specialty distribution of physicians and financing of graduate medical education;
- utilization review and quality of care, including the effectiveness of Peer Review Organizations and other quality assurance programs;
- options to constrain the costs of health care to employers, including incentives under Medicare;
- medical malpractice reforms; and
- physician licensing and certification.

The Commission is also required to comment on the President's budget recommendations affecting physician payment under Medicare.

Commission Publications

Since its creation in 1986, the Physician Payment Review Commission has submitted an annual report to the Congress each March. These reports address a range of policy issues reflected in its congressional mandate with a special focus on those issues of most immediate interest to the Congress. The Commission also publishes three congressionally mandated reports each spring on the Volume Performance Standard (VPS) system, access to care for Medicare beneficiaries, and beneficiary financial liability under the Medicare Fee Schedule. Reports on the VPS system have been published annually since 1990. Reports on access to care and beneficiary financial liability have been published annually since 1991.

The Commission's other publications include reports mandated by legislation; studies specifically requested by congressional committees and members; staff background papers, project reports, and analyses; and results from Commission-sponsored research by outside groups. All Commission publications, described below, can be obtained at no charge by writing the Commission at 2120 L Street NW, Suite 200, Washington, DC 20037, by calling the office at 202-653-7220, or by faxing any requests to 202-653-7238. Please include the title and number or date of the publication and allow two to four weeks for delivery.

REPORTS MANDATED BY THE CONGRESS

Annual Reports to Congress

These reports, as well as corresponding executive summaries, have been published each year since 1987. Among the topics covered in these reports are issues related to development and implementation of the Medicare Fee Schedule, volume

performance standards, Medicare managed care, health system reform, Medicaid managed care and beneficiary access, ensuring quality, graduate medical education, medical malpractice reform, risk adjustment, coverage decisions, practice guidelines, nonphysician practitioners, and antitrust.

The Costs of Providing Screening Mammography, No. 89-2 (June 1989)

Under the Medicare Catastrophic Coverage Act of 1988, the Commission was required to study the cost of providing screening mammography in a variety of settings and at different volume levels for women 65 and older. This report presents the results of Commission analyses of these costs and discusses the quality of screening mammography and patient compliance.

Fee Update and Medicare Volume Performance Standards (published annually since 1990)

Each year, in this report required by the Omnibus Budget Reconciliation Act of 1989 (OBRA89), the Commission comments on the recommendations made by the Secretary of Health and Human Services on setting Medicare Volume Performance Standards and updating physician fees. It also makes its own recommendations for fee updates and for setting standards for Medicare physician expenditure growth, and describes the trends in Medicare spending and changes in physician practice patterns affecting those trends. Past reports have included recommendations that would change the structure of the VPS policy to strengthen incentives to control volume growth and to correct for distortions in relative payments resulting from the current use of separate standards for different groups of services.

Monitoring Access of Medicare Beneficiaries (published annually since 1991)

OBRA89 also directed the Commission to review and comment on the Secretary's report on monitoring changes in the utilization of, access to, and appropriateness of care. In these reports, the Commission reviews the Secretary's plans, presents analyses of access, and outlines its future work plan to monitor and analyze changes in utilization and access.

Monitoring the Financial Liability of Medicare Beneficiaries (published annually since 1991)

OBRA89 also required that, beginning in 1992, the Secretary of Health and Human Services monitor charges on unassigned claims and develop plans to address significant increases in beneficiary liability and issue a report on these topics. The Commission report, which reviews and comments on the Secretary's findings, presents Commission analysis of charges, assignment and participation rates, and balance billing under Medicare's fee-for-service program.

Physician Payment under Medicaid, No. 91-4 (July 1991)

This report on Medicaid physician payment was mandated by the Congress in OBRA89. It provides an overview of the Medicaid program, analyzes available research on the relationship between Medicaid fee levels and access to care, and presents the findings from a 1990 Commission survey of state Medicaid

programs concerning physician payment methodologies. The implications of raising Medicaid fees to Medicare levels are also examined.

Comments on the President's Budget for Fiscal Years 1993 and 1994 (published June 1992 and 1993)

In this report required by mandate, the Commission comments on provisions in the President's budget affecting Medicare, and other selected health programs.

OTHER REPORTS REQUESTED BY THE CONGRESS

Optional Payment Rates for Physicians: An Analysis of Section 402 of H.R.3626, unnumbered (March 1992)

This technical report, prepared at the request of the chair of the House Committee on Ways and Means, analyzes a section of the chair's bill to establish payment rates based on the Medicare Fee Schedule that could be adopted by private payers. It considers adjustments that private payers would have to make, issues related to administration and implementation, and the potential impact on physicians, private payers, and patients.

Expenditure Limits: Design and Implementation Issues, No. 93-5 (July 1993)

This report was prepared in response to a request by the chair of the subcommittee on Health of the House Committee on Ways and Means to consider issues involved in design and implementation of a global budgeting system as it relates to physicians' services. Issues considered include (1) allocation of a national budget among types of health services, (2) availability of data to support establishment and allocation of the national budget, and (3) establishment of maximum payment rates for enforcing budgetary limits. The Commission's experience with the design and implementation of Medicare physician payment reform provides a framework for the analysis.

Study of Behavioral Offset for Radiology Services, unnumbered (July 1993)

Prepared at the request of the chairs of three committees—Senate Finance, House Ways and Means, and House Energy and Commerce—this report examines radiologists' responses to the Medicare Fee Schedule. The report analyzes changes in payment for radiology services from 1989 to 1992 as well as radiologists' volume offset. It concludes there was no reason to exempt radiology from volume offset reductions.

Payment for Trauma and Critical Care Services, No. 94-4 (July 1994)

This report was requested by the Senate Finance Committee and the House Committees on Ways and Means and Energy and Commerce. It reviews the services provided by trauma and critical care specialists, assessing issues arising from current payment policies and recent changes introduced by the

Health Care Financing Administration (HCFA). The report proposes recommendations both for monitoring the effects of the recent HCFA changes and for testing the application of a global payment to cover trauma services provided by physicians in hospitals designated to care for the most complex trauma patients.

Joint Report to the Congress on Medicare Managed Care (October 1995)

This report, issued jointly with the Prospective Payment Assessment Commission, is a primer on Medicare managed care. The report summarizes the work of both commissions on issues of beneficiary enrollment, plan participation, payment policy, ensuring quality and access, and assessing data needs and capabilities.

OTHER COMMISSION REPORTS

Variation in Medicare Global Service Policies: Relationship to Current Payment and Implications for a Fee Schedule, No. 89-2 (November 1989)

This report presents the results of a Commission survey on the component services Medicare carriers include in their global fees for each of four common operations. It describes the survey methods and discusses policy implications.

Medicare's Share in U.S. Physicians' Revenues, No. 89-4 (December 1989)

This report presents Commission analysis of the share of physicians' revenues from Medicare-covered services. It refines previous estimates by adding in Medicare cost sharing and excluding specialties that see few Medicare patients.

Survey of Visits and Consultations, No. 91-1 (April 1991)

This report presents results from a Commission-sponsored survey of physicians designed to provide information for revising visit and consultation codes and assigning relative values to them. The report describes the study design, methods, and results. Key issues considered include physician time involved in visits, the relationship between physician time and work, the role of physician-employed clinical personnel, and current use of visit codes.

Pre- and Postoperative Visits Associated with Surgical Global Services, No. 91-2 (August 1991)

This report presents the results of a Commission project to develop pre- and postoperative visit patterns for major surgical procedures. Data was collected from surgical specialty societies, Medicare claims, and a national survey of practicing surgeons. Information presented in this report supports the Commission's recommendation that these visit patterns be used as the basis for payment for these services within the surgical global policy under the Medicare Fee Schedule.

Comments on the Notice of Proposed Rulemaking for the Medicare Fee Schedule, No. 91-6 (August 1991)

In June 1991, HCFA published a Notice of Proposed Rulemaking that outlined plans for implementation of the Medicare Fee Schedule beginning January 1, 1992. The Commission's report reviews a number of policy and technical issues concerning fee schedule implementation, focusing on calculation of the conversion factor and the scale of relative work. Specific issues considered include budget neutrality, asymmetry, the volume offset, categorization and refinement of values for invasive services, patterns of work for visits, and application of the relative value scale to the Medicare population.

The Role of Specialty Societies and Physicians in the Commission's Evaluation of Relative Work Values, No. 91-7 (November 1991)

This report describes the work of an interspecialty panel of health professionals convened by the Commission to comment on development of the scale of relative work for the Medicare Fee Schedule. It describes comments made by panelists and specialty societies concerning the clinical reasonableness of the relative work values and cross-specialty links released in Phase II of the Hsiao Study.

Practice Expense under the Medicare Fee Schedule: A Resource-Based Approach, No. 92-1 (April 1992)

This research report describes the Commission's efforts to develop resource-based practice expense relative values. It focuses on three issues: the types of data required to develop resource-based relative values, the difficulty in collecting these data, and the decisions and issues that arise throughout the data collection and relative value calculation process. Analyses are presented that estimate payment levels across service families, specialties, and settings. A research agenda is outlined to advance further development of the resource-based approach.

Background Papers Presented at the Commission's Conference on Profiling, No. 92-2 (April 1992)

In January 1992, the Commission held a conference to learn what is known about the appropriateness of present uses of physician profiling and to identify what would be required to realize the full potential of this technique. This report includes four papers commissioned for the conference. Issues covered include data needs, the potential and limitations of profiling, the impact of profiles on medical practice, and public access to profiling information.

Payment for Professional Liability Insurance Expense under the Medicare Fee Schedule, No. 92-7 (December 1992)

This report presents results of the Commission's efforts to develop resource-based relative values for the malpractice component of the Medicare Fee Schedule. It describes an approach based on using professional liability insurance premiums to determine the relative risk of each service.

SELECTED EXTERNAL RESEARCH REPORTS

These reports present complete results from Commission-sponsored projects. Most of these projects are referenced in other Commission reports.

Assignment and the Participating Physician Program: An Analysis of Beneficiary Awareness, Understanding, and Experience, No. 89-1 (Washington, DC: Mathematica Policy Research, Inc., September 1989)

Financial Incentives and Medical Practice: Evidence from Ontario on the Effect of Changes in Physician Fees on Medical Care Utilization, No. 89-3 (Ontario, Canada: Centre for Health Economics and Policy Analysis, McMaster University, December 1989)

Physicians and the Medicare Fee Schedule: A Look at the Medicare Program and Other Payers in a Changing Practice Environment, unnumbered (New York: Louis Harris and Associates, Inc., February 1993)

Survey of Physicians about the Medicare Program and Fee Schedule, unnumbered (Chicago: National Opinion Research Center, May 1994)

A Comparison of Alternative Approaches to Risk Measurement, No. 1 (Minneapolis, MN: Park Nicollet Medical Foundation, November 1994)

Models of Care for Inner City Populations, No. 2 (Washington, DC: Center for Health Policy Research, George Washington University, November 1994)

Arrangements between Managed Care Plans and Physicians: Results from a 1994 Survey of Managed Care Plans, No. 3 (Washington, DC: Mathematica Policy Research, Inc., February 1995)

Results of the 1994 National Survey of Physicians, No. 4 (Rockville, MD: Project HOPE and the Gallup Organization, September 1995).

Identifying Hotspots of Poor Access to Care, No. 5 (Washington, DC: National Committee to Preserve Social Security and Medicare, April 1996).

Glossary

ACRONYMS

AAMC	Association of American Medical Colleges
AAPCC	Adjusted Average Per Capita Cost
AARP	American Association of Retired Persons
ACG	Ambulatory Care Group
ACIR	Advisory Commission on Intergovernmental Relations
ACR	Adjusted Community Rate
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
AHCPR	Agency for Health Care Policy and Research, HHS
AMA	American Medical Association
APR	Adjusted Payment Rate
ASC	Ambulatory Surgical Center
BCBS	Blue Cross Blue Shield
BMAD	Part B Medicare Annual Data Files
CBO	Congressional Budget Office
CBS	Medicare Current Beneficiary Survey
CHPS	Center for Health Policy Studies
CMP	Competitive Medical Plan
CMSA	Consolidated Metropolitan Statistical Area
CPEP	Clinical Practice Expert Panel
CPI	Consumer Price Index
CPI-U	Consumer Price Index for Urban Consumers
CPR	Customary, Prevailing, and Reasonable
CPS	Current Population Survey
CPT	Current Procedural Terminology
CRG	Cost-Related Group
CRS	Congressional Research Service
DCG	Diagnostic Cost Group
DEMPAQ	Developing and Evaluating Methods to Promote Ambulatory Care Quality
DME	Durable Medical Equipment
DRG	Diagnosis-Related Group

DSH	Disproportionate Share Hospital
EKG	Electrocardiogram
EM	Evaluation and Management
EOMB	Explanation of Medicare Benefits
EPO	Exclusive Provider Organization
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ERISA	Employee Retirement Income Security Act of 1974
ESRD	End Stage Renal Disease
FAS	Financial Accounting Standard
FASB	Financial Accounting Standards Board
FDA	Food and Drug Administration, HHS
FEHBP	Federal Employees Health Benefits Program
FQHC	Federally Qualified Health Center
FRIO	Full Replacement Insurance Only
FSA	Fee Schedule Area
FY	Fiscal Year
GAF	Geographic Adjustment Factor
GAO	U.S. General Accounting Office
GDP	Gross Domestic Product
GHAA	Group Health Association of America
GME	Graduate Medical Education
GPCI	Geographic Practice Cost Index
HCFA	Health Care Financing Administration, HHS
HCPCS	HCFA Common Procedure Coding System
HCPP	Health Care Prepayment Plan
HEDIS	Health Plan Employer Data and Information Set
HER	Health Economics Research, Inc.
HHS	U.S. Department of Health and Human Services
HI	Hospital Insurance
HIAA	Health Insurance Association of America
HIO	Health Insuring Organization
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HSA	Health Service Area
HUD	U.S. Department of Housing and Urban Development
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICF	Intermediate Care Facility
IDE	Investigational Device Exemption
IMG	International Medical Graduate
IOM	Institute of Medicine
IPA	Independent Practice Association
IRS	Internal Revenue Service

MCBS	Medicare Current Beneficiary Survey
MEI	Medicare Economic Index
MIG	Medicare Insured Group Demonstration
MMIS	Medicaid Management Information System
MPR	Mathematica Policy Research, Inc.
MPRS	Medical Policy Retrieval System
MSA	Medical Savings Account or Metropolitan Statistical Area
MSIS	Medicaid Statistical Information System
NAIC	National Association of Insurance Commissioners
NAM	National Association of Manufacturers
NAMCS	National Ambulatory Medical Care Survey
NCH	National Claims History
NCQA	National Committee for Quality Assurance
NDG	Network Design Group
NGA	National Governors' Association
NHIS	National Health Interview Survey
NIH	National Institutes of Health, HHS
NLM	National Library of Medicine, HHS
NMES	National Medical Expenditure Survey
NMIHS	National Maternal and Infant Health Survey
NORC	National Opinion Research Center
NPP	Nonphysician Practitioner
NRMP	National Resident Matching Program
OACT	Office of the Actuary, HCFA, HHS
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of the Inspector General, HHS
OMB	Office of Management and Budget
OPM	Office of Personnel Management
PAR	Participating Physician and Supplier Program
PCCM	Primary Care Case Management
PHO	Physician-Hospital Organization
PHP	Prepaid Health Plan
PHS	Public Health Service, HHS
POS	Point of Service
PPO	Preferred Provider Organization
PPRC	Physician Payment Review Commission
PPS	Prospective Payment System
PRO	Peer Review Organization
ProPAC	Prospective Payment Assessment Commission
PSO	Provider-Sponsored Organization
QDWI	Qualified Disabled and Working Individual
QMB	Qualified Medicare Beneficiary
RBRVS	Resource-Based Relative Value Scale

RFP	Request for Proposals
RTI	Research Triangle Institute
RUC	RVS Update Committee
RVS	Relative Value Scale
RVU	Relative Value Unit
SAF	Standard Analytical Files
SIPP	Survey of Income and Program Participation
SLMB	Specified Low-Income Medicare Beneficiary
SMI	Supplementary Medical Insurance
SMRF	State Medicaid Research Files
SMS	Socioeconomic Monitoring System, AMA
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
TEG	Technical Expert Group
UCR	Usual, Customary, and Reasonable
UMWA	United Mine Workers of America
UR	Utilization Review
USPCC	U.S. Per Capita Cost
VPS	Volume Performance Standard

LEGISLATION (LISTED CHRONOLOGICALLY)

HMO Act	Health Maintenance Organization Act of 1973, P.L. 93-222, enacted December 29, 1973.
ERISA	Employee Retirement Income Security Act of 1974, P.L. 93-406, enacted September 2, 1974.
OBRA80	Omnibus Budget Reconciliation Act of 1980, P.L. 96-499, enacted December 5, 1980.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248, enacted September 3, 1982.
DEFRA	Deficit Reduction Act of 1984, P.L. 98-369, enacted July 18, 1984.
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, enacted April 7, 1986.

OBRA86	Omnibus Budget Reconciliation Act of 1986, P.L. 99-509, enacted October 21, 1986.
OBRA87	Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, enacted December 21, 1987.
MCCA	Medicare Catastrophic Coverage Act of 1988, P.L. 100-360, enacted July 1, 1988; repealed December 13, 1989.
OBRA89	Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, enacted December 19, 1989.
OBRA90	Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, enacted November 3, 1990.
OBRA93	Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, enacted August 10, 1993.
Social Security Act Amendments of 1994	Social Security Act Amendments of 1994, P.L. 103-432, enacted October 31, 1994.

TERMS

Access: The ability to obtain needed medical care.

Adjusted Average Per Capita Cost (AAPCC): A county-level estimate of the average cost incurred by Medicare for each beneficiary in the fee-for-service system. See Medicare Risk Contract, U.S. Per Capita Cost.

Adjusted Community Rate (ACR): Estimated payment rates that health plans with Medicare risk contracts would have received for their Medicare enrollees if paid their private market premiums, adjusted for differences in benefit packages and service use. Health plans estimate their ACRs annually and adjust subsequent year supplemental benefits or premiums to return any excess Medicare revenue above the ACR to enrollees. See Adjusted Average Per Capita Cost, Medicare Risk Contract.

Adjusted Payment Rate (APR): The Medicare capitated payment to risk-contract HMOs. For a given plan, the APR is determined by adjusting county-level AAPCCs to reflect the relative risks of the plan's enrollees. See Adjusted Average Per Capita Cost.

Age-at-Issuance Rating: A method for establishing health insurance premiums whereby an insurer's premium is based on the age of individuals when they first purchased health insurance coverage.

Age-Attained Rating: A method for establishing health insurance premiums whereby an insurer's premium is based on the current age of the beneficiary. Age-attained-rated premiums increase as the purchaser grows older.

Aid to Families with Dependent Children (AFDC) program: A program established by the Social Security Act of 1935, providing cash payments to needy children (and their caretakers) who lack support because at least one parent is dead, disabled, continuously absent from the home, or unemployed. Eligible families must meet income and resource criteria specified by the state.

Allowed Charge: The amount Medicare approves for payment to a physician. Typically, Medicare pays 80 percent of the approved charge and the beneficiary pays the remaining 20 percent. Physicians may bill beneficiaries for an additional amount above the approved charge. See Balance Billing.

Assignment: A process under which Medicare pays its share of the allowed charge directly to the physician or supplier. Medicare will do this only if the physician accepts Medicare's allowed charge as payment in full (guarantees not to balance bill). Medicare provides other incentives to physicians who accept assignment for all patients under the Participating Physician and Supplier Program. See Balance Billing, Nonparticipating Physicians, Participating Physician, Participating Physician and Supplier Program.

Balance Billing: In Medicare and private fee-for-service health insurance, the practice of billing patients in excess of the amount approved by the health plan. See Allowed Charge.

Behavioral Offset: The change in the number and mix of services that is projected to occur in response to a change in fees. A 50 percent behavioral offset means that half the savings from fee reductions will be offset by increased volume and intensity of services. Also referred to as volume offset.

Beneficiary: Someone who is eligible for or receiving benefits under an insurance policy or plan. The term is commonly applied to people receiving benefits under the Medicare or Medicaid programs or covered under a private health insurance plan.

Benefit Package: Services covered by a health insurance plan and the financial terms of such coverage, including cost sharing and limitations on amounts of services. See Cost Sharing, Standard Benefit Package.

Bonus Payment: An additional amount paid by Medicare for services provided by physicians in Health Professional Shortage Areas. Currently, the bonus payment is 10 percent of Medicare's 80 percent share of allowed charges. See Allowed Charge, Health Professional Shortage Area.

Budget Neutrality: For the Medicare program, adjustment of payment rates when policies change so that total spending under the new rules is expected to be the same as it would have been under the previous payment rules.

Bundled Payment: A single comprehensive payment for a group of related services.

Buy-In: Refers to instances where a state Medicaid program agrees to pay the Medicare premiums and cost sharing for members of a specified group.

Capitation: A health insurance payment mechanism in which a fixed amount is paid per person to cover services; in other words, a fixed, per capita payment. Capitation may be used by purchasers to pay health plans or by plans to pay providers.

Carrier: A private contractor that administers claims processing and payment for Part B services. See Supplementary Medical Insurance.

Carve-Out Coverage: Method of integrating payment for health benefits provided by Medicare and an employer. Typically, carve-out plans deduct the amount Medicare pays for a service from the amount the employer's plan would be willing to pay for the same service and pays the difference. The beneficiary is generally responsible for any balance remaining on the bill, as well as for the deductible and coinsurance requirements of the employer plan's.

Case Management: Monitoring and coordinating the delivery of health services for individual patients to enhance care and manage costs; often used for patients with specific diagnoses or who require high-cost or extensive health care services.

Coding: A mechanism for identifying and defining physicians' services. See Current Procedural Terminology (CPT).

Coinsurance: A type of cost sharing where the insured party and insurer share payment of the approved charge for covered services in a specified ratio after payment of the deductible. Under Medicare Part B, the beneficiary pays coinsurance of 20 percent of allowed charges. See Allowed Charge, Copayment, Cost Sharing, Deductible.

Community Rating: A method for establishing health insurance premiums whereby an insurer's premium is the same for everyone in a premium class within a specific geographic area. See Premium.

Competitive Bidding: A pricing method that elicits information on costs through a bidding process to establish payment rates that reflect the costs of an efficient health plan or health care provider.

Competitive Medical Plan (CMP): A health plan that is eligible for a Medicare risk contract (although it is not a federally qualified HMO) because it meets specified requirements for service provision, payment, and financial solvency. See Federally Qualified HMO.

Conversion Factor: The multiplicative factor used to translate relative value units into dollar amounts for physician payments under a fee schedule.

Conversion Factor Update: Annual percentage change to the conversion factor, which is either established by the Congress or set by a formula to reflect whether actual expenditure growth from two years earlier fell below or above the target rate. See Conversion Factor, Performance Standard, Sustainable Growth Rate, Sustainable Growth Rate System, Volume Performance Standard System.

Coordinated Coverage: Method of integrating benefits payable under more than one health insurance plan (for example, Medicare and retiree health benefits). Coordinated coverage is typically orchestrated so that the insured's benefits from all sources do not exceed 100 percent of allowable medical expenses. Coordinated coverage may require beneficiaries to pay some deductibles or coinsurance.

Copayment: A type of cost sharing where the insured party is responsible for paying a fixed dollar amount per service. Sometimes used more generally as a synonym for cost sharing. See Coinsurance, Cost Sharing, Deductible.

Cost Contract: See Medicare Cost Contract.

Cost Sharing: A health insurance policy provision that requires the insured party to pay a portion of the costs of covered services. Deductibles, coinsurance, copayment, and balance bills are types of cost sharing. See Balance Billing, Coinsurance, Copayment, Deductible.

Coverage Decision: A decision by a health plan whether to pay for or provide a medical service or technology for particular clinical indications.

Current Procedural Terminology (CPT): The coding system for physicians' services developed by the CPT Editorial Panel of the American Medical Association; basis of the Medicare coding system for physicians' services. See Coding, HCFA Common Procedures Coding System.

Customary Charge: One of the screens previously used to determine a physician's payment for a service under Medicare's customary, prevailing, and reasonable payment system. Customary charges were calculated as the physician's median charge for a given service over a prior 12-month period. See Customary, Prevailing, and Reasonable.

Customary, Prevailing, and Reasonable (CPR): The method of paying physicians under Medicare from 1965 until implementation of the Medicare Fee Schedule in January 1992. Payment for a service was limited to the lowest of (1) the physician's billed charge for the service, (2) the physician's customary charge for the service, or (3) the prevailing charge for that service in the community. Similar to the usual, customary, and reasonable system used by private insurers. See Customary Charge, Medicare Fee Schedule, Prevailing Charge.

Deductible: A type of cost sharing where the insured party pays a specified amount of approved charges for covered medical services before the insurer will assume liability for all or part of the remaining covered services. See Coinsurance, Copayment, Cost Sharing.

Defined Contribution Coverage: A funding mechanism for health benefits whereby employers make a specific dollar contribution toward the cost of insurance coverage for employees, but make no promises about specific benefits to be covered.

Diagnosis-Related Groups (DRGs): A system of classifying patients on the basis of diagnoses for purposes of payment to hospitals. See Prospective Payment System.

Dual Eligible: A Medicare beneficiary who also receives the full range of Medicaid benefits offered in his or her state.

Effectiveness: The net health benefits provided by a medical service or technology for typical patients in community practice settings.

Efficacy: The net health benefits achievable under ideal conditions for carefully selected patients.

Evaluation and Management (EM) Service: A nontechnical service, such as a visit or consultation, provided by most physicians to diagnose and treat diseases and counsel patients.

Exclusion Coverage: Method of integrating payment for health benefits provided by Medicare and an employer. Medicare payments are subtracted from actual claims and the employer-sponsored plan's benefits are applied to the balance. Such coverage generally leaves the beneficiary responsible for the employer's plan's cost sharing and deductibles.

Exclusive Provider Organization (EPO): A type of preferred provider organization in which the patient is required to use the provider network, and no coverage is available for out-of-network services. See Preferred Provider Organization.

Experience Rating: A system used by insurers to set premium levels based on the insured's past loss experience. For example, rating may be based on service utilization for health insurance or on liability experience for professional liability insurance. See Community Rating.

Failsafe Budget Mechanism: An overall limit on Medicare spending proposed in a conference agreement (H.R. 2491) passed by the Congress in November 1995. The mechanism would obtain scored savings of $270 billion by the year 2002 based on economic assumptions of the Congressional Budget Office, and would provide a safeguard against unrestrained growth in Medicare spending. See Scored Savings.

Federally Qualified HMO: An HMO that has satisfied certain federal qualifications pertaining to organizational structure, provider contracts, health service delivery information, utilization review and quality assurance, grievance procedures, financial status, and marketing information, as specified in Title XIII of the Public Health Service Act. See Health Maintenance Organization.

Fee for Service: A method of paying health care providers for individual medical services rendered, as opposed to paying them salaries or capitated payments. See Capitation.

Fee Schedule: A list of predetermined payment rates for medical services. See Medicare Fee Schedule.

Fee Schedule Payment Areas: A geographic area within which payment for a given service under the Medicare Fee Schedule does not vary. See Geographic Adjustment Factor.

Five-Year Review: A review of the accuracy of Medicare's relative value scale that the Health Care Financing Administration is required to conduct every five years.

Gaming: Gaining advantage by using improper means to evade the letter or intent of a rule or system.

Generalists: Physicians who are distinguished by their training as not limiting their practice by health condition or organ system, who provide comprehensive and continuous services, and who make decisions about treatment for patients presenting with undifferentiated symptoms. Typically include family practitioners, general internists, and general pediatricians.

Geographic Adjustment Factor (GAF): The GAF for each service in a particular payment area is the average of the area's three geographic practice cost indexes weighted by the share of the service's total RVUs accounted for by the work, practice expense, and malpractice expense components of the Medicare Fee Schedule. See Geographic Practice Cost Index, Relative Value Units.

Geographic Practice Cost Index (GPCI): An index summarizing the prices of resources required to provide physicians' services in each payment area relative to national average prices. There is a GPCI for each component of the Medicare Fee Schedule: physician work, practice expense, and malpractice expense. The indexes are used to adjust relative value units to determine the correct payment in each fee schedule payment area. See Fee Schedule Payment Area, Medicare Fee Schedule.

Graduate Medical Education (GME): The period of medical training that follows graduation from medical school; commonly referred to as internship, residency, and fellowship training. See Undergraduate Medical Education.

Gross Domestic Product (GDP): The total current market value of all goods and services produced domestically during a given period; differs from the gross national product by excluding net income that residents earn abroad.

Group-Model HMO: An HMO that pays a medical group a negotiated, per capita rate, which the group distributes among its physicians, often under a salaried arrangement. See Health Maintenance Organization, Independent Practice Association, Network-Model HMO, Staff-Model HMO.

Guaranteed Issue: The requirement that each insurer and health plan accept everyone who applies for coverage and guarantee the renewal of that coverage as long as the applicant pays the premium.

Guaranteed Renewable: The requirement that each insurer and health plan continue to renew health policies purchased by individuals as long as the person continues to pay the premium for the policy.

HCFA Common Procedure Coding System (HCPCS): A Medicare coding system based on CPT, but supplemented with additional codes. See Coding, Current Procedural Terminology.

Health Care Prepayment Plan (HCPP): A health plan with a Medicare cost contract to provide only Medicare Part B benefits. Some administrative requirements for these plans are less stringent than those of risk contracts or other cost contracts. See Medicare Cost Contract, Medicare Risk Contract.

Health Maintenance Organization (HMO): A type of managed-care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Benefits are typically financed through capitation with limited copayments, and services are furnished through a system of affiliated providers. See Group-Model HMO, Independent Practice Association HMO, Managed Care, Network-Model HMO, Staff-Model HMO.

Health Plan: An organization that acts as insurer for an enrolled population. See Fee for Service, Managed Care, Medical Savings Account.

Health Professional Shortage Area (HPSA): An urban or rural geographic area, a population group, or a public or nonprofit private medical facility that the Secretary of Health and Human Services determines is being served by too few health professionals. Physicians who provide services in HPSAs qualify for the Medicare bonus payment. Replaces Health Manpower Shortage Area. See Bonus Payment.

Hospital Insurance (HI): The part of the Medicare program that covers the cost of hospital and related post-hospital services. Eligibility is normally based on prior payment of payroll taxes. Beneficiaries are responsible for an initial deductible per spell of illness and copayments for some services. Also called Part A coverage or benefits.

Independent Practice Association (IPA): An HMO that contracts with individual physicians or small physician groups to provide services to HMO enrollees at a negotiated per capita or fee-for-service rate. Physicians maintain their own offices and can contract with other HMOs and see other fee-for-service patients. See Group-Model HMO, Health Maintenance Organization, Network-Model HMO, Staff-Model HMO.

Intensity of Service: See Volume and Intensity of Services.

Limiting Charge: The maximum amount that a nonparticipating physician is permitted to charge a Medicare beneficiary for a service; in effect, a limit on balance billing. Starting in 1993 the limiting charge has been set at 115 percent of the Medicare-allowed charge. See Allowed Charge, Balance Billing, Nonparticipating Physician.

Locality: See Fee Schedule Payment Area.

Loss Ratio: The ratio of benefits paid out to premiums collected for a particular type of insurance policy. Low loss ratios indicate that a small proportion of premium dollars were paid out in benefits, while high loss ratios indicate that a high percentage of the premium dollars were paid out as benefits.

Malpractice Expense: The cost of professional liability insurance incurred by physicians. A component of the Medicare relative value scale. See Relative Value Scale.

Managed Care: Any system of health service payment or delivery arrangements where the health plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan. See Health Maintenance Organization, Independent Practice Association, Preferred Provider Organization.

Medicaid: A program of federal matching grants to the states to provide health insurance for categories of the poor and medically indigent. States determine eligibility, payments, and benefits consistent with federal standards.

Medical Savings Account (MSA): A health insurance option consisting of a high-deductible insurance policy and a tax-advantaged savings account. Individuals would pay for their own health care up to the annual deductible by withdrawing from the savings account or paying out of pocket. The insurance policy would pay for most or all costs of covered services once the deductible is met.

Medical Underwriting: See Underwriting.

Medicare Cost Contract: A contract between Medicare and a health plan under which the plan is paid on the basis of reasonable costs to provide some or all of Medicare-covered services for enrollees. See Health Care Prepayment Plan, Medicare Risk Contract.

Medicare Economic Index (MEI): An index that tracks changes over time in physician practice costs. From 1975 through 1991, increases in prevailing charge screens were limited to increases in the MEI. It is the starting point for updates under the VPS. See Prevailing Charge, Volume Performance Standard System.

Medicare Fee Schedule: The resource-based fee schedule Medicare uses to pay for physicians' services. Replaced the CPR payment method. See Resource-Based Relative Value Scale; Conversion Factor; Geographic Practice Cost Index; Customary, Prevailing, and Reasonable.

MedicarePlus: Program to offer private health plans to Medicare beneficiaries, as proposed under the conference agreement passed by the Congress in November 1995 (H.R. 2491).

Medicare Risk Contract: A contract between Medicare and a health plan under which the plan receives monthly capitated payments to provide Medicare-covered services for enrollees, and thereby assumes insurance risk for those enrollees. A plan is eligible for a risk contract if it is a federally qualified HMO or a competitive medical plan. See Adjusted Average Per Capita Cost, Competitive Medical Plan, Medicare Cost Contract.

Medicare SELECT: A form of Medigap insurance that allows insurers to experiment with the provision of supplemental benefits through a network of providers. Coverage of supplemental benefits is often limited to those services furnished by participating network providers and emergency, out-of-area care.

Medigap Insurance: Privately purchased individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles and coinsurance and balance bills, as well as payment for services not covered by Medicare. Medigap insurance must conform to one of ten federally standardized benefit packages.

National Claims History (NCH) System: A HCFA data reporting system that combines both Part A and Part B claims in a common file. The NCH system became fully operational in 1991.

Network-Model HMO: An HMO that contracts with several different medical groups, often at a capitated rate. Groups may use different methods to pay their physicians. See Group-Model HMO, Health Maintenance Organization, Independent Practice Association, Staff-Model HMO.

Nominal Value: Measurement of an economic amount in terms of current prices. See Real Value.

Nonparticipating Physician: A physician who does not sign a participation agreement and, therefore, is not obligated to accept assignment on all Medicare claims. See Assignment, Participating Physician, Participating Physician and Supplier Program.

Nonphysician Practitioner (NPP): A health care professional who is not a physician. Examples include advanced practice nurses and physician assistants.

Outcome: The consequence of a medical intervention on a patient.

Paid Amount: The portion of a submitted charge that is actually paid by both third-party payers and the insured, including copayments and balance bills. For Medicare this amount may be less than the allowed charge if the submitted charge is less, or it may be more because of balance billing. See Allowed Charge, Balance Billing, Payment Rate, Submitted Charge.

Part A: See Hospital Insurance.

Part B: See Supplementary Medical Insurance.

Partial Capitation: An insurance arrangement where the payment made to a health plan is a combination of a capitated premium and payment based on actual use of services; the proportions specified for these components determine the insurance risk faced by the plan.

Partial Risk Contract: A contract between a purchaser and a health plan, in which only part of the financial risk is transferred from the purchaser to the plan. See Self-Insured Health Plan.

Participating Physician: A physician who signs a participation agreement to accept assignment on all Medicare claims for one year. See Assignment.

Participating Physician and Supplier Program (PAR): A program that provides financial and administrative incentives for physicians and suppliers to agree in advance to accept assignment on all Medicare claims for a one-year period. See Assignment.

Payment Rate: The total amount paid for each unit of service rendered by a health care provider, including both the amount covered by the insurer and the consumer's cost sharing; sometimes referred to as payment level. Also used to refer to capitation payments to health plans. For Medicare payments to physicians, this is the same as the allowed charge. See Allowed Charge.

Peer Review Organization (PRO): An organization contracting with HCFA to review the medical necessity and quality of care provided to Medicare beneficiaries.

Performance Measure: A specific measure of how well a health plan does in providing health services to its enrolled population. Can be used as a measure of quality. Examples include percentage of diabetics receiving annual referrals for eye care, screening mammography rate, and percentage of enrollees indicating satisfaction with care.

Performance Standard: The target rate of expenditure growth set by the Volume Performance Standard system. See Volume Performance Standard System.

Physician-Hospital Organization (PHO): An organization that contracts with payers on behalf of one or more hospitals and affiliated physicians. The PHO may also undertake utilization review, credentialing, and quality assurance. Physicians retain ownership of their own practices, maintain significant business outside the PHO, and typically continue in their traditional style of practice.

Physician Work: A measure of the physician's time, physical effort and skill, mental effort and judgment, and stress from iatrogenic risk associated with providing a medical service. A component of the Medicare relative value scale. See Relative Value Scale.

Point-of-Service (POS) Plan: A managed-care plan that combines features of both prepaid and fee-for-service insurance. Health plan enrollees decide whether to use network or nonnetwork providers at the time care is needed and usually are charged sizable copayments for selecting the latter. See Health Plan, Health Maintenance Organization, Preferred Provider Organization.

Portability: The requirement that insurers waive any preexisting condition exclusion for someone who was previously covered through other insurance as recently as 30 to 90 days earlier. See Preexisting Condition Exclusion.

Practice Expense: The cost of nonphysician resources incurred by the physician to provide services. Examples are salaries and fringe benefits received by the physician's employees, and the expenses associated with the purchase and use of medical equipment and supplies in the physician's office. A component of the Medicare relative value scale. See Relative Value Scale.

Practice Expense Relative Value: A value that reflects the average amount of practice expenses incurred in performing a particular service. All values are expressed relative to the practice expenses for a reference service whose value equals one practice expense unit. See Relative Value Scale.

Practice Guideline: An explicit statement about the benefits, risks, and costs of particular courses of medical action based on the medical literature and expert judgement. Intended to help practitioners, patients, and others make decisions about appropriate health care for specific clinical conditions.

Preexisting Condition Exclusion: A practice of some health insurers to deny coverage to individuals for a certain period, for example, six months, for health conditions that already exist when coverage is initiated. See Portability.

Preferred Provider Organization (PPO): A managed-care plan that contracts with networks or panels of providers to furnish services and be paid on a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on the preferred list, but may use nonnetwork providers as well. See Managed Care.

Premium: An amount paid periodically to purchase health insurance benefits.

Prevailing Charge: One of the screens that determined a physician's payment for a service under the Medicare CPR payment system. In Medicare, it was the 75th percentile of customary charges, with annual updates limited by the MEI. See Customary Charge; Customary, Prevailing, and Reasonable; Medicare Fee Schedule; Medicare Economic Index.

Professional Liability Insurance (PLI): The insurance physicians purchase to help protect themselves from the financial risks associated with medical liability claims.

Profiling: Expressing a pattern of practice as a rate—some measure of utilization (costs or services) or outcome (functional status, morbidity, or mortality) aggregated over time for a defined population of patients—to compare with other practice patterns. May be done for physician practices, health plans, or geographic areas.

Prospective Payment System (PPS): The Medicare system used to pay hospitals for inpatient hospital services; based on the DRG classification system. See Diagnosis-Related Groups.

Quality Assurance: A formal, systematic process to improve quality of care that includes monitoring quality, identifying inadequacies in delivery of care, and correcting those inadequacies.

Real Value: Measurement of an economic amount corrected for change in price over time (inflation), thus expressing a value in terms of constant prices. See Nominal Value.

Refinement: The correction of relative values in Medicare's relative value scale that were initially set incorrectly.

Reinsurance: An insurance arrangement where an insurer pays a premium into a pool, and any claims paid by the insurer above a predefined dollar level are covered in whole or in part by the pool.

Relative Value: A value that reflects a comparison with a standard. See Relative Value Scale.

Relative Value Scale (RVS): An index that assigns weights to each medical service; the weights represent the relative amount to be paid for each service. The RVS used in the development of the Medicare Fee Schedule consists of three components: physician work, practice expense, and malpractice expense. See Malpractice Expense, Medicare Fee Schedule, Physician Work, Practice Expense, Resource-Based Relative Value Scale.

Relative Value Unit (RVU): The unit of measure for a relative value scale. RVUs must be multiplied by a dollar conversion factor to become payment amounts. See Conversion Factor, Relative Value, Relative Value Scale.

Replacement Insurance: Insurance that substitutes coverage under one policy for coverage under another policy.

Resource-Based Relative Value Scale (RBRVS): A relative value scale based on the resources involved in providing a service. See Relative Value Scale.

Revenue Share: The proportion of a practice's total revenue devoted to a particular type of expense. For example, the practice expense revenue share is that proportion of revenue used to pay for practice expense.

Risk Adjuster: A measure used to adjust payments made to a health plan on behalf of a group of enrollees in order to compensate for spending that is expected to be lower or higher than average, based on the health status or demographic characteristics of the enrollees.

Risk Contract: See Medicare Risk Contract.

Risk Selection: Any situation in which health plans differ in the health risk associated with their enrollees because of enrollment choices made by the plans or enrollees, that is, where one health plan's expected costs differ from another's due to underlying differences in their enrolled populations.

Scored Savings: Amount of savings expected to be obtained from enacting new legislation. Estimated by the Congressional Budget Office by calculating the difference in spending projected under current law and under the proposed legislation.

Secondary Insurance: Any insurance that supplements Medicare coverage. The three main sources for secondary insurance are employers, privately purchased Medigap plans, and Medicaid.

Self-Insured Health Plan: Employer-provided health insurance in which the employer, rather than an insurer, is at risk for its employees' medical expenses.

Site-of-Service Differential: The difference in the amount paid when the same service is performed in different practice settings, for example, an outpatient visit in a physician's office or a hospital clinic.

Staff-Model HMO: An HMO in which physicians practice solely as employees of the HMO and usually are paid a salary. See Group-Model HMO, Health Maintenance Organization.

Standard Benefit Package: A defined set of health insurance benefits that all insurers are required to offer. See Benefit Package.

Submitted Charge: The charge submitted by a provider to the patient or a payer. See Paid Amounts.

Supplemental Security Income (SSI): A federal income support program for low-income disabled, aged, and blind persons. Eligibility for the monthly cash payments is based on the individual's current status without regard to previous work or contributions.

Supplementary Medical Insurance (SMI): The part of the Medicare program that covers the costs of physicians' services, outpatient laboratory and X-ray tests, durable medical equipment, outpatient hospital care, and certain other services. This voluntary program requires payment of a monthly premium, which covers 25 percent of program costs. Beneficiaries are responsible for a deductible and coinsurance payments for most covered services. Also called Part B coverage or benefits.

Supplier: A provider of health care services, other than a practitioner, that is permitted to bill under Medicare Part B. Suppliers include independent laboratories, durable medical equipment providers, ambulance services, orthotists, prosthetists, and portable X-ray providers.

Sustainable Growth Rate: The target rate of expenditure growth set by the Sustainable Growth Rate system. Similar to the performance standard under the Volume Performance Standard system, except that the target depends on growth of gross domestic product instead of historical trends. See Sustainable Growth Rate System, Volume Performance Standard System, Performance Standard.

Sustainable Growth Rate System: A revision to the Volume Performance Standard system, proposed by the Congress and the Administration. This system would provide an alternative mechanism for adjusting fee updates for the Medicare Fee Schedule. The mechanism would use a single conversion factor, base target rates of growth on growth of gross domestic product, and change the method for calculating the conversion factor update to eliminate the two-year delay. See Volume Performance Standard System, Conversion Factor Update.

Technology Assessment: In health policy, a synthesis of information on the safety, effectiveness, and cost of a service or technology to predict how providing it would affect patients and the health care system.

Undergraduate Medical Education: The medical training provided to students in medical school. See Graduate Medical Education.

Underwriting: The process by which an insurer determines whether and on what basis it will accept an application for insurance. Some insurers use medical underwriting to exclude individuals, groups, or coverage for certain health conditions that are expected to incur high costs.

Unified Insurance: Health insurance coverage that is provided through a single insurance policy.

U.S. Per Capita Cost (USPCC): The national average cost per Medicare beneficiary, calculated annually by HCFA's Office of the Actuary. See Adjusted Average Per Capita Cost, Adjusted Payment Rate, Medicare Risk Contract.

Usual, Customary, and Reasonable (UCR): A method used by private insurers for paying physicians based on charges commonly used by physicians in a local community. Sometimes called customary, prevailing, and reasonable charges. See Customary, Prevailing, and Reasonable.

Utilization Review (UR): The review of services delivered by a health care provider or supplier to determine whether those services were medically necessary; may be performed on a concurrent or retrospective basis.

Volume and Intensity of Services: The quantity of health care services per enrollee, taking into account both the number and the complexity of the services provided.

Volume Offset: See Behavioral Offset.

Volume Performance Standard (VPS) System: The VPS system provides a mechanism to adjust fee updates for the Medicare Fee Schedule based on how annual increases in actual expenditures compare with previously determined performance standard rates of increase.

Work Relative Value: A value that reflects the average amount of physician work incurred in performing a particular service. All values are expressed relative to the work required for a reference service whose value equals one work unit. See Relative Value Scale.

Wraparound Coverage: Method of integrating payment for health benefits provided by Medicare and an employer. Wraparound coverage does not duplicate Medicare benefits, but focuses on coverage for Medicare deductibles and coinsurance, as well as benefits Medicare does not cover.

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